

**FACE SHEET**

**FISCAL YEAR COVERED BY THE PLAN:** 2006

STATE NAME: Nebraska

DUNS #: 808819957 (Nebraska Department of Health and Human Services)

**I. AGENCY TO RECEIVE GRANT**

AGENCY: Nebraska Department of Health and Human Services

ORGANIZATIONAL UNIT: Division of Behavioral Health Services

STREET ADDRESS: PO Box 98925

CITY: Lincoln State: NE ZIP CODE: 68509-8925

TELEPHONE: (402) 479-5125 FAX: (402) 479-5162

**II. OFFICIAL IDENTIFIED BY GOVERNOR AS RESPONSIBLE FOR  
ADMINISTRATION OF CMHS BLOCK GRANT**

NAME: Nancy Montanez TITLE: Director

AGENCY: Nebraska Department of Health and Human Services

ORGANIZATIONAL UNIT:     

STREET ADDRESS: P.O. Box 95044

CITY: Lincoln State: NE ZIP CODE: 68509- 5044

TELEPHONE: (402) 471-9106 FAX: (402) 471-0820

**III.STATE FISCAL YEAR**

FROM: July 2005 TO: June 2006

**IV. PERSON TO CONTACT WITH ANY QUESTIONS REGARDING THE  
APPLICATION**

NAME: James S. Harvey, LCSW TITLE: Quality Improvement Coordinator

AGENCY: Nebraska Department of Health and Human Services

ORGANIZATIONAL UNIT: Division of Behavioral Health Services

STREET ADDRESS: PO Box 98925

CITY: Lincoln State: NE ZIP CODE: 68509-8925

TELEPHONE: (402) 479-5125 FAX: (402) 479-5162 EMAIL: jim.harvey@hhss.ne.gov

## **EXECUTIVE SUMMARY**

This application was prepared to meet the requirements for the Federal Community Mental Health Services Block Grant application for FY2006.

The adult section of this application reports upon the current statewide changes underway impacting the mental health system in Nebraska. As reported to the Behavioral Health Oversight Commission of the Legislature (Neb. Rev. Stat. 71-818), there is a wide variety of services being developed across the state including Acute & Subacute Inpatient, Crisis Response Teams, Crisis Respite, Dual Disorder Residential, Medication Management services, Community Support (mental health, substance abuse, and emergency), Day Rehabilitation, Telemedicine, Short Term Residential, Psychiatric Residential Rehabilitation, Crisis Stabilization Center, Psychiatric Respite, Halfway House and Assertive Community Treatment. Also, progress was made in addressing the development of Supported Housing with the passage of LB 40 (2005). This bill authorized the use of state funds to provide Housing-related assistance for very low-income adults with serious mental illness. Housing-Related Assistance includes rental payments, utility payments, security and utility deposits, and other related costs and payments.

The child section of this application reports the State has significant challenges in appropriately addressing the behavioral health needs of its children and their families. One in four families of children with serious mental health problems were encouraged to relinquished custody of their child just to access behavioral healthcare that they could not afford. Through the leadership of the Governor and the Legislature's Health and Human Services Committee, Nebraska enacted major legislation this spring designed to ensure access to behavioral health services, create an appropriate array of community-based services and a continuum of care, coordinate behavioral healthcare with primary healthcare services, develop services that are research based and consumer focused, ensure consumer involvement as a priority in all aspects of service planning and delivery, and develop funding that is fully integrated and supports a plan of treatment. Nebraska has been awarded a Children's Mental Health state infrastructure grant to support systems of care at the state level which should also help address these issues.

The State Advisory Committee on Mental Health Services is concerned about a number of issues. One discussed at length is the evidenced based practice of supported employment. The committee feels there needs to be integration into the community by business partners who appreciate and are willing to assist consumers by developing work-based sites. At the same time, Supported Employment needs to be carefully implemented due to the possibilities that consumers on SSI may lose their benefits. Another issue is improving on culturally competent services. The emphasis is on trying to improve providers capacity to meet the National Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS).

The Federal Community Mental Health Services Block Grant represents 3.5% of the estimated 2006 state expenditures for Mental Health community services in Nebraska excluding all Medicaid Behavioral Health funds. When combining the community and Regional Center funds for FY06, the Federal Community Mental Health Services Block Grant is 1.8% of the total estimated 2006 state expenditures.

**Table of Contents**

<b>Face Sheet .....</b>	<b>1</b>
<b>Executive Summary .....</b>	<b>2</b>
<b>Table of Contents .....</b>	<b>3</b>
<b>PART B. Administrative Requirements, Fiscal Planning Assumptions, and Special Guidance</b>	
I. Public Comments on the State Plan.....	4
II. Set-Aside for Children’s Mental Health Services Report .....	6
III. Maintenance of Effort Report (MOE).....	6
IV. Fiscal Planning Assumptions & Criterion 5 – Financial Resources.....	7
V. State Mental Health Planning Council Requirements.....	9
 <b>PART C State Plan</b>	
Section I. Description of State Service System .....	17
Section II. Identification and Analysis of the System’s Strengths, Needs, & Priorities.....	22
Weaknesses of Service System – Analysis Unmet Needs/Gaps.....	26
 Section III. Performance Goals and Action Plans to Improve the Service System	
a) Adult Plan	
Statement of State’s Adult priorities and plans to address unmet needs (Goals) .....	44
Adult Criteria to be addressed in the State Plan	
Comprehensive community-based mental health services .....	53
Mental health system data epidemiology .....	62
Targeted services to rural and homeless populations .....	70
Management systems .....	74
 b) Children’s Plan	
STATE PLAN CONTEXT – Children and Families Section .....	79
Children Criteria to be addressed in the State Plan	
Comprehensive community-based mental health services .....	94
Mental health system data epidemiology .....	101
Children’s services.....	103
Targeted services to rural and homeless populations .....	110
Management systems .....	113
 c) National Outcome Measures.....	114
 <b>Letter from Governor for Designation .....</b>	<b>118</b>
<b>Attachments: Federal Funding Agreements, Certifications and Assurances.....</b>	<b>119</b>
Attachment A: Comm MH Services Block Grant Funding Agreements (FY2006), Certifications, Disclosure of Lobbying Activities and Assurances	

**PART B. SECTION I. (5)**

**Federal Requirement: Public Comment On The State Plan**

1. The Nebraska FY 2006 Application for the Community Mental Health Services Block Grant summarizes the planning, policy development, and implementation work taking place within the Nebraska Behavioral Health System.

- The adult plan reports the work occurring within the Nebraska Behavioral Health Reform which is subject to a wide variety of public input including but not limited to the Behavioral Health Oversight Commission of the Legislature (Neb. Rev. Stat. 71-818).
- The content used to prepare the adult and child plans are reviewed in public forums such as
  - State Advisory Committee on Mental Health Services (Neb. Rev. Stat. §71-814),
  - Six Regional Governing Boards [Neb. Rev. Stat. § 71-808(1)] consisting of one county board member from each county in the region as assigned under Neb. Rev. Stat. § 71-807. The reviews include the Plans of Expenditure, annual contracts with the Nebraska Division of Behavioral Health Services, and other related policy documents from the Nebraska Department of Health and Human Services.
  - Six Regional Advisory Committees [Neb. Rev. Stat. § 71-808(2)] consisting of consumers, providers, and other interested parties review materials before they are submitted to the Regional Governing Boards.







2. The draft document ready for public review was posted on the HHS Mental Health Services Web site on August 1, 2005. The public input was closed on August 17, 2005.

<http://www.hhs.state.ne.us/beh/mh/mh.htm>

***Mental Health Services***

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**Fiscal Year 2006 Mental Health Block Grant Public Review Documents**

<b>Document</b>	<b>Format 1</b>	<b>Format 2</b>
Kid's Services	 <a href="#">MS Word</a>	 <a href="#">PDF</a>
Adult Services	 <a href="#">MS Word</a>	 <a href="#">PDF</a>
Public Review Sheet	 <a href="#">MS Word</a>	 <a href="#">PDF</a>

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3. The State Advisory Committee on Mental Health Services is the primary mechanism used to obtain public comment on the “State Plan”, as presented in the application for the Federal Community Mental Health Services Block Grant. Here is how public meeting notice is accomplished.

The public meeting notice goes into the Lincoln Journal Star at least 10 days in advance of the Advisory Committee meetings and BH Council Meetings. There is one public meeting notice

done for all 3 advisory Committees (The State Advisory Committee on Mental Health Services, the State Advisory Committee on Substance Abuse Services, and the State Advisory Committee on Problem Gambling & Addiction Services) and the BH Council.

Publishing in the Lincoln Journal Star only is suffice for meeting the public meeting notice in a statewide newspaper. The minutes of these meetings and agendas are published at least 10 days in advance of the meetings on the HHSS website: <http://www.hhs.state.ne.us>. Below is the public meeting notice published in the Lincoln Journal Star for the May 10, 2005 meeting.

NOTICE OF PUBLIC MEETING – Notice is hereby given that the Nebraska Department of Health and Human Services, Division of Behavioral Health Services, has scheduled the following Advisory Committee Meetings and a Behavioral Health Council Meeting for Tuesday May 10th, 2005 at the Country Inn/Suites, 5353 North 27<sup>th</sup> Street, Lincoln, Nebraska.

Advisory committee meetings from 9:00 a.m. to Noon:

- The State Advisory Committee on Mental Health Services,
- The State Advisory Committee Substance Abuse Services, and
- The State Advisory Committee on Problem Gambling and Addiction Services

From 12:00 p.m. to 4:00 p.m.: The Behavioral Health Council

The agenda for each meeting is available for viewing from 8:00 a.m. to 5:00 p.m. during business days at the Nebraska Department of Health and Human Services, Division of Behavioral Health Services, located at Folsom and West Prospector Place, Building #14, Lincoln, NE 68522. The agenda's for the above meetings will also be posted on the State public meeting notice website at [www.ne.gov](http://www.ne.gov). ten days in advance of the May 10<sup>th</sup>, 2005 meetings. If auxiliary aids or reasonable accommodations are needed for attendance at the meeting, please call the Division of Behavioral Health Services, (402) 479-5249, or for persons with hearing impairments, please call 800-833-7353 for the Nebraska Relay System TDD number. Advance notice of seven days is needed when requesting an interpreter.

Federal Requirements

PART B. Administrative Requirements, Fiscal Planning Assumptions, and Special Guidance

Section II. Set-Aside for Children's Mental Health Services Report

Section III. Maintenance of Effort Report (MOE)

**Section II. Set-Aside for Children's Mental Health Services**

DATA REPORTED BY: State Fiscal Year (July 1 to June 30)

State Expenditures for Children's Services			
Calculated 1994	Actual 2003	Actual 2004	Actual/Estimated 2005 *
<b>\$620,801</b>	<b>\$3,872,010</b>	<b>\$3,642,336</b>	<b>\$3,429,684</b>

**\*CHILDREN'S SET ASIDE NOTE:** (1) Local contractors have the flexibility to move funds per the local priorities and needs between adult and children's services; therefore, the amount of funds may fluctuate between adults and children's services annually. (2) Revised billings were approved for June 2005 in August 2005; therefore, the actual for FY05 will change when the payments have cleared the system. (3) The federal Children's CMHS grant no cost extension funds were fully expended in FY04 and the funding for children has decreased as a result.

**Section III. Maintenance of Effort (MOE)**

DATA REPORTED BY: State Fiscal Year (July 1 to June 30)

State Expenditures for Mental Health Services		
Actual 2003	Actual 2004	Actual/Estimated 2005 *
<b>\$29,036,852</b>	<b>\$35,678,871</b>	<b>\$36,970,889</b>

**\*MOE NOTE:** (1) The Actual/Estimated 2005 includes \$5.5 million for one time reform services (non-recurring) -- continuation is unknown at this time. (2) In 2005, the Legislature changed from funding mental health and substance abuse services separately. **Currently, all community aid funds are appropriated to Behavioral Health Aid;** local contractors have the flexibility to move funds around per the local priorities and needs in mental health and substance abuse services; therefore, the amount of funds may fluctuate between mental health and substance abuse services as well as between adult and children's services. (3) Not included in this total are the state general funds (\$62,379,003) expended in FY05 for mental health services provided in the three state operated psychiatric inpatient hospitals (Regional Centers). If Regional Center funding were included, the total expenditures for FY05 mental health services in Nebraska would be \$105,205,275.

### **FISCAL PLANNING ASSUMPTIONS**

Federal Requirements - This section covers both Adult and Children Services

- PART B. Section IV. Fiscal Planning Assumptions - Intended use of the Block Grant funds.
- Criterion 5: Management Systems - Describes financial resources.

### **SECTION III – STATE PLAN**

#### **A. Fiscal Planning Assumptions for Adults and Children**

The fiscal planning assumption for the Nebraska Community Mental Health Services Block Grant is based on the final allocation from FY2005 = \$2,086,159.

**TABLE 1:** FY2006 TOTAL MENTAL HEALTH BLOCK GRANT FUNDS BY SERVICES AND TARGET POPULATION

	<b>CMHS Block Grant \$</b>		<b>% of Total Blk Grt \$ (non shaded)</b>
1. Adult Residential, Rehab, and Support Services	\$501,527		24%
2. Adult Treatment Services	\$583,712		27%
<i>Total Services for Adults</i>		\$1,085,239	52%
3. Services for Children/Youth	\$851,541		41%
<i>Total Services for Children/Youth</i>		\$851,541	41%
4. Rural Service Equity		\$40,071	2%
5. Peer Review		\$5,000	1%
6. State Administration (5%)		\$104,308	5%
<i>FY2006 TOTAL FUNDS (100 %)</i>		\$2,086,159	100%

Footnotes for Table 1:

1. Adult Residential, Rehabilitation and Support Services funded with mental health block grant funds include Community Support-MH (all regions), Day Rehabilitation (all regions), Psych Residential Rehab (Regions 3-6), Vocational Support (Regions 1, 3, & 4), Day Support (Regions 1-3) and Dual Residential (Region 5).
2. Adult Treatment Services funded with mental health block grant funds include Day Treatment (Regions 5 & 6), Assessment-MH (Regions 1, 2, 3, 5 & 6), Outpatient Therapy-MH (all regions), Outpatient Therapy-SPMI/CD (Regions 3 & 5) and Medication Management (all regions).
3. Services for SED Children/Youth funded with mental health block grant funds include Professional Partner (all regions), Professional Partner-Rural School Wraparound (Regions 1 & 4), Day Treatment (Regions 1 & 3) Therapeutic Consultation (Regions 2 & 5), and Services for MI Children/Youth funded with mental health block grant funds include Intensive Outpatient-MH (Region 4).
4. Rural Service Equity funds are allocated as needed to rural areas.
5. For the Independent Peer Review required under section 1943 of the Community Mental Health Services Block Grant funding agreements to assess the quality, appropriateness, and efficacy of services.
6. State Administration (5%) is used for Consumer Empowerment (see Adult Goal #2: Empower Consumers).

The Mental Health community services aid funding being reported for FY2006 includes the Federal Mental Health Block Grant, PATH Homeless Grant, State General Funds, Tobacco Cash, and Mental Health Rental Assistance Cash funds designated for behavioral health services, expended or allocated to community mental health. State General and Tobacco unexpended FY05 funds have been reappropriated on a one time non-recurring basis to assist with behavioral health reform services to help move the Nebraska public system to more community services and fewer state operated Regional Center services.

State funds for adults are used to match federal Vocational Rehabilitation funds through the Nebraska Department of Education Division of Vocational Rehab per a State Cooperative Agreement. \$460,567 of State funds match approximately \$1,701,719 federal VR funds for FY06 (21.3% State to 78.7% federal match rate) to serve persons with SPMI in vocational rehab services.

**TABLE 2:** FY2006 TOTAL PRELIMINARY ALLOCATION OF ALL FUNDS FOR COMMUNITY MENTAL HEALTH SERVICES

<b>FUNDED MH AID PROGRAMS</b>	<b>TOTAL \$</b>
Region 1-6 Contracts	\$38,488,846
Region MH Medicaid Rehab Option Services - State Match for Medicaid FFP	\$5,836,380
Region 1-6 MH Rental Assistance & One Time Housing Construction/Renovation Contracts	\$3,945,000
Region 1, 3, 5 & 6 PATH Homeless Services Contracts	\$288,000
Native American Tribe Contracts	\$503,928
ASO/Managed Care Contract	\$277,080
ASO/Managed Care – State Match for Medicaid FFP	\$425,000
Women's BH Coalition and Peer Review	\$18,436
Consumer / Family Support Projects	\$132,890
Indigent Medications	\$2,000,000
Rural MH Crisis Counseling Voucher Program	\$152,990
MH Statewide Training	\$61,252
Unallocated-Cash Flow/ Rural Service Equity	\$40,071
<i>TOTAL \$</i>	<b>\$52,169,873</b>

The Federal Community Mental Health Services Block Grant represents 3.5% of the estimated 2006 state expenditures for Mental Health community services in Nebraska excluding all Medicaid Behavioral Health funds. \$63,361,644 is allocated in FY06 to operate the three state psychiatric inpatient Regional Centers. When combining the community and Regional Center funds for FY06, the total is \$110,691,546 allocated to mental health services in Nebraska. When considering both funding allocations, the Federal Community Mental Health Services Block Grant would then be 1.8% of the total estimated 2006 state expenditures.

**V. State Mental Health Planning Council Requirements**

1. Membership Requirements
2. State Mental Health Planning Council Membership List and Composition
3. Planning Council Charge, Role and Activities
4. State Mental Health Planning Council Comments and Recommendations

**MENTAL HEALTH PLANNING COUNCIL**

The Nebraska Behavioral Health Services Act, Neb. Rev. Stat. § 71-814 (Laws 2004, LB 1083) authorizes the State Advisory Committee on Mental Health Services. §71-814 (2) (a) says the committee shall serve as the State's Mental Health Planning Council as required by Public Law 102-321. The statute §71-814 (1) defines the membership of this committee.

It is important to note that the State Advisory Committee on Mental Health Services is one of four advisory groups created under the Nebraska Behavioral Health Services Act. The State Advisory Committee on Substance Abuse Services (§71-815) and the State Advisory Committee on Problem Gambling and Addiction Services (§71-816) are also appointed by the Governor and function in a role similar to the Mental Health Committee. The State Behavioral Health Council (§ 71-813) is made of members of the three advisory committees and are selected by the Governor (three per committee) or elected by committee members (seven per committee). For more information on these State Advisory Committees or the State Behavioral Health Council see the Official Nebraska Government Website at [www.hhs.state.ne.us/beh/mh/sacmhs.htm](http://www.hhs.state.ne.us/beh/mh/sacmhs.htm).

**- State Mental Health Planning Council Membership List and Composition**

The Governor appoints the membership of the State Advisory Committee on Mental Health Services. Here are the appointments as of July 16, 2004. New appointments may be expected before the next scheduled meeting on November 8, 2005.

TABLE 1. List of Planning Council Members

	NAME	TYPE OF MEMBERSHIP	AGENCY OR ORGANIZATION	ADDRESS, PHONE & FAX
<b>Consumers</b>				
1	Wayne Adamson	Adult with Serious Mental Illness	Consumer / Region 3	1363 W. "E" Apt. #4 Hastings, NE 68901-5869 402-463-0532
2	Jimmy Burke	Adult with Serious Mental Illness	Consumer / Region 5	4603 Prescott Ave. Lincoln, NE 68506 402-483-4086
3	Richard Ellis	Adult with Serious Mental Illness	Consumer / Region 5	4123 Pace Blvd Lincoln, NE 68502 402-420-7415
4	Wesley Legan	Adult with Serious Mental Illness	Consumer / Region 6	616 N. 46th Street Apt. #5 Omaha, NE 68132 402-556-3702

5	Darlene Richards	Adult with Serious Mental Illness	Consumer / Region 1	310 W. 5th Bridgeport, NE 69336 308-262-2950
6	VACANT	Adult with Serious Mental Illness	Consumer / Region	
Family Members of Children with SED				
7	Dwain Fowler	Family Members of Children with SED	Family Child w/ SED / Region 3	P.O. Box 95 Franklin, NE 68939 308-425-3134
8	Clint Hawkins	Family Members of Children with SED	Family Child w/ SED / Region 4	P.O. Box 722 Woodlake, NE 69221 402-967-3012
9	VACANT	Family Member of Child with SED	Family Child w/ SED / Region	
Family Members of Adults with SMI				
10	Nancy Kratky	Family Members of Adults with SMI	Family Adult w/ SMI / Region 6	1204 N. 101 Circle Omaha, NE 68114 402-390-0956
11	Susan Krome	Family Members of Adults with SMI	Family Adult w/ SMI / Region 5	7704 Ringneck Drive Lincoln, NE 68506 402-484-8653
12	Mary Wells	Family Members of Adults with SMI	Family Adult w/ SMI / Region 3	HC 71, Box 114-A Anselmo, NE 68813 308-749-2675
Other Representatives				
13	James Deaver	regional governing board member	Regional Behavioral Health Authority	32290 Road 751 Imperial, NE 69033 308-352-4000
14	Beth Baxter	regional administrator	Regional Behavioral Health Authority	Region 3 Mental Health & Substance Abuse Admin. 4009 6 <sup>th</sup> Ave., Suite 65 Kearney, NE 68848-2555 308-237-5113, Ext. 222
15	Allen Bartels	Provider of behavioral health services	Provider	603 N. Harvard Ave. Harvard, NE 68944 402-772-8291
16	Dr. Maria Prendes-Lintel	provider of behavioral health services	Provider	633 Eastridge Drive Lincoln, NE 68510 402-483-1116

17	Beth Wierda	State Department of Education	State Employee	Department of Education Special Education P.O. Box 94987 NSOB 6 <sup>th</sup> Floor Lincoln, NE 68509-4987 402-471-2471
18	Frank Lloyd	Division of Vocational Rehabilitation	State Employee	4409 Browning Place Lincoln, NE 68516 402 420-2202
19	VACANT - Division of B H Services Admin.	HHS Mental Health	State Employee	
20	Chris Hanus	HHS social services	State Employee	HHSS/Protection & Safety 301 Centennial Mall South NSOB 3rd Floor Lincoln, NE 68509
21	Cec Brady	HHS Medicaid	State Employee	HHS/F&S/Medicaid 301 Centennial Mall South NSOB 5th Floor Lincoln, NE 68509
22	Scott Ford**	NE Comm on Law Enforcement and Criminal Justice	Other (not state employees or providers)	1505 "G" Street - Police Department South Sioux City, NE 68776 402-494-7555
23	Lara Huskey	Housing Office Dept of Economic Development	State Employee	P.O. Box 94666 NSOB 6 <sup>th</sup> Floor Lincoln, NE 68509 402-471-3759

\*\* Mr. Ford is the representative for criminal justice representing the State criminal justice system. On July 16, 2004, Mr. Scot Ford was appointed by Governor Johanns to serve on the State Advisory Committee on Mental Health Services. Scot Ford is the Police Chief / Public Safety Director for South Sioux City, NE, a member of the Nebraska Crime Commission and Nebraska's representative to the International Association of Chiefs of Police. Mr. Ford is not a state employee. The Nebraska Commission on Law Enforcement and Criminal Justice (also known as the Nebraska Crime Commission) is designated as the principle State agency with respect to criminal justice. [see their web site at <<http://www.nol.org/home/crimecom/>>]

TABLE 2. Planning Council Composition by Type of Member

Type of Membership	Number	Percentage of Total Membership
TOTAL MEMBERSHIP	23	100%
Consumers/Survivors/Ex-patients (C/S/X)	5	
Family Members of Children with SED	2	
Family Members of Adults with SMI	3	
Vacancies (C/S/X & family members)	2	
Others (not state employees or providers)	1	
TOTAL C/S/X, Family Members & Others	13	57%
State Employees	5	
Providers / Regional Behavioral Health Authority	4	
Vacancies	1	
TOTAL State Employees & Providers	10	43%

#### MENTAL HEALTH PLANNING COUNCIL

##### - Membership Requirements and Planning Council Charge, Role

The membership requirements as well as Planning Council Charge / Role are specified within the Nebraska Behavioral Health Services Act (Neb. Rev. Stat. §71-814), which established the State Advisory Committee on Mental Health Services in 2004.

§71-814 - State Advisory Committee on Mental Health Services; created; members; duties.

Source: Laws 2004, LB 1083, § 14. Operative date: July 1, 2004.

- (1) The State Advisory Committee on Mental Health Services is created. Members of the committee shall have a demonstrated interest and commitment and specialized knowledge, experience, or expertise relating to the provision of mental health services in the State of Nebraska. The committee shall consist of twenty-three members appointed by the Governor as follows:
  - (a) One regional governing board member,
  - (b) one regional administrator,
  - (c) twelve consumers of behavioral health services or their family members,
  - (d) two providers of behavioral health services,
  - (e) two representatives from the State Department of Education, including one representative from the Division of Vocational Rehabilitation of the State Department of Education,
  - (f) three representatives from the Nebraska Health and Human Services System representing mental health, social services, and Medicaid,
  - (g) one representative from the Nebraska Commission on Law Enforcement and Criminal Justice, and
  - (h) one representative from the Housing Office of the Community and Rural Development Division of the Department of Economic Development.

- (2) The committee shall be responsible to the State Behavioral Health Council and shall
  - (a) serve as the state's mental health planning council as required by Public Law 102-321,
  - (b) conduct regular meetings,
  - (c) provide advice and assistance to the council and the division relating to the provision of mental health services in the State of Nebraska,
  - (d) promote the interests of consumers and their families,
  - (e) provide reports as requested by the council or the division, and
  - (f) engage in such other activities as directed or authorized by the council.

#### MENTAL HEALTH PLANNING COUNCIL

##### - **Activities**

The Nebraska Behavioral Health Services Act (Neb. Rev. Stat. §71-814) established the State Advisory Committee on Mental Health Services in 2004. At the meetings, the State Advisory Committee on Mental Health Services did engage in its state and federal required duties.

- The first official meeting of the State Advisory Committee on Mental Health Services was held on August 19th, 2004 at the Country Inn and Suites in Lincoln, Nebraska. Richard Ellis was elected as the Interim Chair of the Committee. The FY2005 MH Block Grant was also reviewed.
- November 9, 2004 (9:00 a.m. - 5:00 p.m.) was the first official orientation of the Behavioral Health Council in Lincoln, NE. All of the members of the three advisory committees were invited to this orientation. This meeting included Governor Johanns making a personal appearance to thank everyone for their commitment to the Nebraska Behavioral Health Reform (LB1083/2004) and to ask the group to become leaders in the behavioral health reform. The Governor said consumers are the best source of what needs are important. The orientation included showing the SAMHSA video tape entitled, "Partners in Transformation", listing goals essential for a successful transformation. An orientation on the Nebraska Behavioral Health System was completed. The orientation included a discussion on how the State Advisory Committee on Mental Health Services (SACMHS) role with the Federal Community Mental Health Services Block Grant.
- November 10, 2004 (9:00 a.m. – 12:00 p.m.) Lincoln, NE. Approve Bylaws, Elect Officers, Elect Council Members, Federal Community Mental Health Services Block Grant (review FY2004 Implementation Report and Report on the FY2005 Application review on October 21, 2004; Consider the appointment of a subcommittee to advise the Director on the selection of the Program Administrator for the Office of Consumer Affairs and to advise the Program Administrator for the Office of Consumer Affairs. Allen Bartels was elected Chair of the Committee.
- February 8, 2005 (9:00 a.m. - 12:00 p.m.) Lincoln, NE. Report on LB 95, Report on rental assistance, Cultural Competence Goals and Objectives, Consumer Survey results 2004. There was also time for Public Comment.
- May 10, 2005 (9:00 a.m. - 12:00 p.m.) Lincoln, NE. Status of Office of Consumer Affairs, Status of Administrator of the Division of Behavioral Health Services, Consumer Activities, 2005 NAMI Conference in Austin, Texas, Update on State Rental Assistance; Review and Discussion of Unmet Needs/Gaps to be included in 2006 MH Block Grant Application.

- August 9, 2005 (9:00 a.m. - 12:00 p.m.) Lincoln, NE. Addressing issues such as NAMI 2005 Convention, Consumer Scholarships, informed on the status of the BH Division Administrator & Consumer Affairs Office Administrator, Mission, Vision, Direction of Committee, Annual Report to Governor & Legislature, review and comment on the 2006 MH Block Grant Application.
- Future meeting are scheduled for the following dates: November 8, 2005; February 7, 2006; May 9, 2006; August 8, 2006; November 7, 2006

#### Federal Requirements

#### **MENTAL HEALTH PLANNING COUNCIL**

##### **- State Mental Health Planning Council Comments and Recommendations**

Below represents a record of the comments received from the public and members of the State Advisory Committee on Mental Health Services on August 9, 2005.

#### **STATE ADVISORY COMMITTEE ON MENTAL HEALTH SERVICES COMMENTS & RECOMMENDATIONS ON MH BLOCK GRANT APPLICATION**

- Supported Employment - Integration into the community by community business partners who appreciate and are willing to assist consumer developing work based sites. These community based sites need to be willing to accommodate individual differences and strengths for the consumer to work toward successful endeavors.
- Supported Employment - Integration into the community by business partners who appreciate and are willing to assist consumers by developing work based sites. These community based sites need to be willing to accommodate individual differences and strengths in order for the consumer to work toward successful endeavors.
- once you go back to work, you can loose benefits
- As Supported Employment is developed, need to remember to be responsive to individuals illness (the natural course of the illness, it is a chronic illness, people are vulnerable to illness), system needs to be responsive, need to beware of possible loss of benefits.
- Want to move into supported employment, need to understand constraints from other systems, need to be aware of unintended consequences, need to deal with constraints (such as regulations), we need to develop our structure to address these issues.
- on culturally competent services: CLAS Standards – can't use services due to service provider(s) not able to speak the language, there are huge gaps in service, propose a sub-committee to address the standard issues involved, suggests accessing the limited English proficiency population that is using MH Services in Region, what cultural & appropriate services are being offered, training of cultural competency and how it work with interrupters, stigma reduction training involved with the groups. NOTE: CLAS Standards refers to the National Standards for Culturally and Linguistically Appropriate Services in Health Care issued by the U.S. Department of Health and Human Services in December 2000.
- Providers willing to implement CLAS Standards, there are funding issueS to pay for interpreters

- Funding is an infrastructure issue ... need to put money into having interpreters ... it is better to have the provider speaking the consumer's language, thus not needing a system to pay for interpreters; Current structure not there to make it work; need training for providers
- Overall, the grant looks very good. You have provided a comprehensive overview and description of our BH system and service gaps.

#### **PUBLIC COMMENT ON THE ADULT & CHILD/ADOLESCENT PLANS**

- favors peer to peer type services
- The HHS web site has good content. Suggest posting on the HHS web site how to apply to become a member of the committee, the Federal review results and the state response; and the community mental health services budget.
- 30 minutes of review and comment on the scheduled agenda for the State Advisory Committee on Mental Health Services under New Business is not adequate. This is one of the most important tasks for the Committee. It sends the wrong message about the Committee.
- Protest: The published time on the agenda noted the comment section of the committee meeting started around 11:10 a.m. The chair moved the agenda item to an earlier time. This could be a problem for members of the public to make comments.
- Not enough input on the goal setting for the grant as noted in last year's letter
- Current roster of the committee shows only two family member of SED youth. This is not adequate for representation on this committee.
- Grave Problem: suggests a primary goal be set to develop a plan regarding changing the Family's need to relinquish custody in order to access services. Nebraska is 50<sup>th</sup> state in the union on number of state wards per capita. Need a plan to address this.
- The notices may be posted on-line prior to the meetings but what good is that if no one has been notified or prompted in a timely fashion to go to that site for that information.
- Use the "Consumer Mailing List developed and maintained under Consumer Empowerment.
- ... there is no plan in development to implement these directives. [referring to Neb. Rev. Stat. 71-803 on the purposes for the Public behavioral health system ... including (3)(d) consumer involvement as a priority in all aspects of service planning and delivery].
- consumers and this Committee should be involved and provide input on service definitions.
- There are several state and even federal committees on which the state employee who is a consumer is the only consumer. The narrative seems to imply this is a source of pride while others, including myself, believe if there are not sufficient numbers of consumer who have been educated and supported to make an impact, then a singular individual, no matter how stellar is not adequate.
- I believe and hope that we are moving toward a more transparent system and the significant increase of consumers involvement.

## Nebraska State Advisory Committee on Mental Health Services

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August 27, 2004

Ms. LouEllen M. Rice  
Grants Management Officer  
Office of Program Services, Division of Grants Management  
Substance Abuse and Mental Health Services Administration  
1 Choke Cherry Road  
Rockville, MD 20857

Dear Ms. Rice:

Please regard this letter as documentation demonstrating that the FY 2005 Nebraska Community Mental Health Services Block Grant Application was shared with the State Advisory Committee on Mental Health Services.

On May 10, 2005, the committee reviewed and discussed the Grant, focusing on the unmet needs/gaps that would be included in the 2006 Mental Health Block Grant Application. On July 28, 2005 the Nebraska Division of Behavior Health Services mailed the draft of the FY 2006 Nebraska Community Mental Health Services Block Grant Application to the committee members to ensure that members had adequate time to review the draft. The formal review was completed on August 9, 2005 during the meeting of the State Advisory Committee on Mental Health Services.

During the review of the draft, several issues were discussed including the concept of supported employment. The committee feels that there needs to be integration into the community by business partners who appreciate and are willing to assist consumers by developing work-based sites. It was also pointed out that the system needs to be changed so that those working do not lose their benefits.

Culturally competent services was also discussed at length by the committee, with an emphasis on trying to meet the National Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS). It was suggested that a subcommittee be formed to look at the many issues supporting cultural competency.

During the August 9, 2005 meeting there were also comments made by the general public regarding the grant draft. There was praise given to the current HHS web site, however, some members of the public felt that the time allotted by the committee was not enough to adequately review the draft of the Grant. It was suggested that a future primary goal be to develop a plan regarding changing the Family's need to relinquish custody in order to access services.

The draft was approved by the committee on a vote of 12 yes / 1 no / 2 abstain.

Sincerely yours,

Allen Bartels, Chair, Nebraska State Advisory Committee on Mental Health Services

## **PART C. State Plan**

### **Section I. Description of State Service System**

#### **Federal Requirements**

- An overview of the State's mental health system
- A description of how the State mental health agency provides leadership

#### **GOVERNOR**

On December 2, 2004, President Bush announced his nomination of Governor Mike Johanns to be the Secretary of the U.S. Department of Agriculture. At the time, Governor Johanns was midway through his second four-year term. On January 20, 2005 Governor Johanns resigned in order to assume his new duties as Secretary of Agriculture. As a result of this gubernatorial resignation, on January 20, 2005 Dave Heineman became Nebraska's 39th governor.

#### **HHSS**

The Nebraska Partnership Act (1996), effective on January 1, 1997, created the Nebraska Health and Human Services System (HHSS). HHSS is made up of three functional agencies, the Department of Health and Human Services (HHS); the Department of Health and Human Services Finance and Support (HHS/F&S); and the Department of Health and Human Services Regulations and Licensure (HHS/R&L). The State Medicaid authority is located in HHS/F&S. For more information about HHSS visit <<http://www.hhs.state.ne.us/>>.

#### **POLICY CABINET:**

The Nebraska Health and Human Services System (HHSS) Policy Cabinet governs this State of Nebraska agency. The Policy Cabinet consists of the three agency directors, a Policy Secretary, and the Chief Medical Officer. The Governor appoints the HHSS Policy Cabinet. As of July 2005, the HHSS Policy Cabinet is Chris Peterson (Policy Secretary and HHS Regulation & Licensure Interim Director); Dick Nelson (Director, HHS Finance & Support); Nancy Montanez (Director, Health & Human Services) and Blaine Shaffer, M.D.

Over the last year, there have been some changes to the HHSS Policy Cabinet. Steve Curtiss, Director, NE Department of Health and Human Services Finance & Support resigned. Dick Nelson, Director, NE Department of Health & Human Services Regulation & Licensure, was appointed to serve as Director of Finance and Support. Dr. Richard Raymond, the Nebraska's Chief Medical Officer, was appointed to serve as Director of Regulation and Licensure.

In July 2005, Dr. Richard Raymond was confirmed as Undersecretary for Food Safety at the U.S. Department of Agriculture. His last day was July 18, 2005. On July 13, 2005, Governor Heineman announced two interim appointments within HHSS to serve in the roles to be vacated by the departure of Dr. Raymond.

- Effective July 18, Christine Peterson, Policy Secretary for HHSS, will serve as interim director of Regulation and Licensure.
- Dr. Blaine Shaffer, Chief Clinical Officer for HHS Behavioral Health Services, will serve as interim HHSS Chief Medical Officer.

HHS: The Department of Health and Human Services (HHS) has local offices across the state that are organized into five service areas. In addition, the Department oversees 10 facilities, including four Veterans' Homes, three regional centers, two youth rehabilitation and treatment centers, and the Beatrice State Development Center. Organizational Structure for the Department of Health and Human Services (HHS) is Nancy Montanez, Director; Dennis Loose, Chief Deputy Director for Health and Human Services; Ron Sorensen – Behavioral Health Administrator (Community-based Mental Health/Substance Abuse, Compulsive Gambling, Regional Centers, Aging and Disability Services); Mary Boschult (Office of Administration); and Blaine Shaffer, M.D., Interim Chief Medical Officer. Jackie Miller reports to the Chief Medical Officer as a Deputy Director over the Office of Disease Prevention and Health Promotion, Office of Family Health, Office of Minority Health, Office of Public Health, Office of Rural Health and Office of Women's Health.

#### BEHAVIORAL HEALTH ADMINISTRATOR & CHIEF CLINICAL OFFICER

- Neb. Rev. Stat. 71-805 (2) created a new position of Behavioral Health Administrator. The Administrator is appointed by the Governor and confirmed by a majority of the members of the Legislature. On September 17, 2004, Governor Johanns announced the appointment of Richard DeLiberty of Carmel, Indiana to the position of Behavioral Health Administrator. On March 22, 2005, Richard DeLiberty resigned. On March 23, 2005, Governor Heineman named Ronald Sorensen, Deputy Administrator of the Division of Behavioral Health Services, as Nebraska's interim Behavioral Health Services Administrator. On July 27, 2005, Governor Dave Heineman appointed Ronald Sorensen to serve as the Behavioral Health Services Administrator for the State of Nebraska.
- On January 13, 2005, Blaine Shaffer, M.D., was appointed to the position of Chief Clinical Officer for the Division of Behavioral Health Services in the Department of Health and Human Services (HHS). The Nebraska Behavioral Health Services Act, Neb. Rev. Stat. 71-805 (2), created the position of chief clinical officer. The statute requires the chief clinical officer to be a board-certified psychiatrist and to serve as the medical director for the division and all facilities and programs operated by the division.

#### NEBRASKA BEHAVIORAL HEALTH SERVICES ACT

Major changes continue to take place in Nebraska. The **Nebraska Behavioral Health Services Act**, Neb. Rev. Stat. §§ 71-801 to 71-820 (Laws 2004, LB 1083, §§ 1 – 20) was approved by the Governor on April 14, 2004. The "**Nebraska Behavioral Health Services Act**" represents a major reform of the Nebraska Behavioral Health System. For example, § 71-804 (2) defines a "Behavioral Health disorder" as "mental illness or alcoholism, drug abuse, problem gambling, or other addictive disorder". The Nebraska Behavioral Health Services Act establishes a revised framework for the provision of behavioral health services in Nebraska. For more information on the Nebraska Behavioral Health Services Act and the Nebraska's Behavioral Health Reform Initiative, visit the Nebraska Health and Human Services web site and click on "Adult Behavioral Health Reform" <<http://www.hhs.state.ne.us/beh/reform/>>.

## REGIONAL CENTERS

HHS is a direct service provider of mental health services through three State Psychiatric Hospitals (Hastings Regional Center, Lincoln Regional Center, Norfolk Regional Center). One of the intents of the Act is to reduce the necessity and demand for regional center services. Here are some examples from the Act demonstrating this intent: 71-802 (7) says one of the purposes of the Nebraska Behavioral Health Services Act is to “authorize the closure of regional centers”. 71-810 (1) (b) calls for “reducing the necessity and demand for regional center behavioral health services.” and 71-810 (2) says, “The division may reduce or discontinue regional center behavioral health services only if (a) appropriate community-based services or other regional center behavioral health services are available for every person receiving the regional center services that would be reduced or discontinued, (b) such services possess sufficient capacity and capability to effectively replace the service needs which otherwise would have been provided at such regional center, and (c) no further commitments, admissions, or readmissions for such services are required due to the availability of community-based services or other regional center services to replace such services. 71-810 (5) says “ The division may establish state-operated community-based services to replace regional center services”.

### Mechanism to Close a Regional Center

The Nebraska Behavioral Health Systems Act will eventually close the regional centers in Hastings and Norfolk to create more community-based programs for treating behavioral health disorders. In §71-810, the Act provides key directions for the changing of the Behavioral Health System in Nebraska

- (1) instructs the Division to encourage and facilitate the Statewide development and provision of an appropriate array of Community-Based Behavioral Health Services and continuum of care.
- (2) says the Division may reduce or discontinue Regional Center Behavioral Health services only if appropriate community-based services or other Regional Center Behavioral Health services are available for every person receiving the Regional Center services that would be reduced or discontinued.
- (6) says the division is to notify the Legislature and Governor when occupancy of the licensed psychiatric hospital beds of any Regional Center reaches 20% or less of its licensed psychiatric hospital bed capacity on March 15, 2004. The Legislature’s Executive Board may grant the division permission to close the center and transfer any remaining patients to appropriate community-based services.
- (7) states that the provisions of Section 10 are self-executing and require no further authorization or other enabling legislation.

## COMMUNITY MENTAL HEALTH

Under the Nebraska Behavioral Health Services Act; Neb. Rev. Stat. 71-801 to 71-820 (Laws 2004, LB 1083, §§ 1 – 20) the Division of Behavioral Health Services was formed. The primary role involves State administration and management of non-Medicaid public behavioral health services through Regional and direct service contracts. In that capacity, the Division provides a state leadership role as the Mental Health Authority and State Substance Abuse Authority. Key sections under the statute assigning duties to the Division of Behavioral Health Services are

- 71-804 (8) Division means the Division of Behavioral Health Services of the department;
- 71-805 Division of Behavioral Health Services; established; personnel; office of consumer affairs.
- 71-806 Division; powers and duties; rules and regulations
- 71-806 (1) The Division of Behavioral Health Services shall act as the chief Behavioral Health authority for the State of Nebraska.
- 71-810 Division; community-based behavioral health services; duties; reduce or discontinue regional center behavioral health services; powers and duties.
- 71-811 Division; funding; powers and duties.
- 71-812 Behavioral Health Services Fund; created; use; investment.
- 71-813 State Behavioral Health Council
- 71-814 State Advisory Committee on Mental Health Services
- 71-815 State Advisory Committee on Substance Abuse Services
- 71-816 State Advisory Committee on Problem Gambling and Addiction Services
- 71-817 Compulsive Gamblers Assistance Fund; created; use; investment.
- 71-916 Mental health commitment board training

This leadership role involves a number of different areas including but not limited to: Funding, contracting, & monitoring community mental health & substance abuse services; Behavioral Health System Management and Information Management via Administrative Services Only contract with Magellan Behavioral Health.; State Behavioral Health Standards (Regulations, Contracts, other related policy); Training/Technical Assistance; Planning / Define Services / Establish Rates; Professional Partner Services (Mental Health Children's Services only); Consumer Empowerment Projects including Neb. Rev. Stat. §71-805 (3) to establish an Office of Consumer Affairs; Gambling Assistance Program; Substance Abuse Prevention Programs; Mental Health and Substance Abuse funding for Native American Tribes; Mental Health Commitment Board Training (Neb. Rev. Stat. § 71-916); Statewide MH Disaster Preparedness & Response / Critical Incident Stress Management; Pre-admission Screening / Annual Resident Reviews; State Behavioral Health Council (Neb. Rev. Stat. §71-813); State Advisory Committee on Mental Health Services (Neb. Rev. Stat. §71-814); State Advisory Committee on Substance Abuse Services (Neb. Rev. Stat. §71-815); State Advisory Committee on Problem Gambling and Addiction Services (Neb. Rev. Stat. §71-816); Housing-related assistance for very low-income adults with serious mental illness [Neb. Rev. Stat. § 71-812(3)]; Federal Grants Management (such as PATH Homeless Services, SA Needs Treatment Assessment, MH Data Infrastructure Grant).

#### ASO for MH/SA Services

Starting in 1995, there has been a Medicaid managed care contract for mental health and a separate contract for behavioral health. Magellan Behavioral Health handles the Managed Care Administration Service Organization (ASO) Mental Health and Substance Abuse (MH/SA) services contract. Magellan Behavioral Health (Magellan) covers both Medicaid (Managed Care Program and Medical Assistance Program) and the Nebraska Behavioral Health System (NBHS). The contracts cover a three year time period, and a possible three year extension. The Medicaid portion of this started July 1, 2002. This contract was converted to the ASO format. The Nebraska Behavioral Health System (NBHS) contract started January 1, 2003. The Nebraska

Health and Human Services Policy Cabinet recently approved a three year extension to the Magellan contract covering FY2006, FY2007 and FY2008.

ASO Contract & Data Collection - The data base used for community behavioral health programs was moved to Magellan Behavioral Health during the first contract cycle. Community based data collection by Magellan was implemented on July 1, 1997 and community-based utilization management was initiated in December of 1997 for those services requiring authorization.

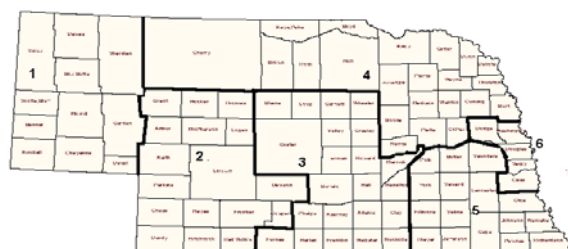
The contract covering Nebraska Behavioral Health System (NBHS) includes the Magellan Behavioral Health data system. Revisions were implemented in October 2003. The revised 117 data fields for the NBHS cover Community mental health, community substance abuse, and the gamblers assistance program. Sections such as demographics, admission status data, children/adol (0-18), history of substance abuse, service / authorization, financial eligibility, discharge status.

#### PART C. STATE PLAN / Section I. Description of State Service System

##### A brief description of regional/sub- State programs

The mental health regions were initially established in 1974. The Nebraska Behavioral Health Services Act, Neb. Rev. Stat. §§ 71-807 to 71-809 revised the regional administration of the Nebraska Behavioral Health System. The Act retained the six geographic behavioral health “regions” as started in 1974. §71-807 assigns all 93 counties to one of six Behavioral Health Regions. The Act renames the regional administrative entity as a **Regional Behavioral Health Authority (RBHA)**, to mirror designation of the Division as the state’s chief behavioral health authority. Regional Governing Boards are retained, consisting of one county board member from each county in the region. The administrator of the RBHA is appointed by the regional governing board. The RBHA is responsible for the development and coordination of publicly funded behavioral health services in the region pursuant to rules and regulations of the Department.

Region	Regional Office	Counties	Population (2000)	% of population
1 (Panhandle)	Scottsbluff	11	90,410	5.3%
2 (West Central)	North Platte	17	102,311	6.0%
3 (South Central)	Kearney	22	223,143	13.0%
4 (Northeast & North Central)	Norfolk	22	216,338	12.6%
5 (Southeast)	Lincoln	16	413,557	24.2%
6 (Eastern)	Omaha	5	665,454	38.9%
Totals		93	1,711,213	100.0%



Funding required of counties for the operation of the RBHA and for the provision of behavioral health services within the region remains the same. Any additional General Funds made available for the provision of community-based services due to any reduction in regional center services may not be included in the county matching fund calculation.

The Act prohibits the regions from directly providing services except under very limited circumstances. §71-809 (2) does provide exceptions. One exception is a regional behavioral health authority may continue to directly provide services it operated on July 1, 2004.

Each regional behavioral health authority must continue to utilize a regional advisory committee consisting of consumers, providers, and other interested parties, and may establish and utilize other task forces or committees as necessary and appropriate to carry out its duties under the act.

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## **SECTION II.**

### **Identification & Analysis of the Service System's Strengths, Needs and Priorities**

Federal Requirements: Part C

Section I.

- Significant achievements in its previous fiscal year
- New developments and issues that affect mental health service delivery in the State
- Legislative initiatives and changes

SECTION II. Identification & Analysis of the Service System's Strengths, Needs and Priorities

- A brief summary of recent significant achievements that reflect progress towards the development of a comprehensive community-based mental health system of care.

This section will be discussing the Nebraska Behavioral Health Reform. The section covers a number of areas including significant achievements during the last year that reflect progress towards the development of a comprehensive community-based mental health system of care, new developments and issues that affect mental health service delivery in the State, as well as legislative initiatives and changes.

### **Nebraska's Behavioral Health Reform Initiative**

For the last several years, Governor Mike Johanns has publicly stated that behavioral health reform was his priority.

- LB 724 (2003): Established a "roadmap" for reform of the public behavioral health system and outlined focus areas for reform.
- LB 710 (2003): Proposed recodification of the Nebraska Mental Health Commitment Act.
- LB 1083 (2004): Implemented the Nebraska Behavioral Health Reform intent.

New developments and issues

LB 40 (2005) amended Neb. Rev. Stat. § 71-812 (Behavioral Health Services Fund) to authorize the use of state funds to provide Housing-related assistance for very low-income adults with serious mental illness. The act became operative on July 1, 2005. LB40 deleted Rental

assistance for adults with serious mental illness under LB1083 (2004) section 101. Housing-Related Assistance includes rental payments, utility payments, security and utility deposits, and other related costs and payments.

LB40A appropriated \$1,845,000 to be distributed to each regional behavioral health authority on a per capita basis no later than thirty days after receipt of such funds and shall only be used for one-time funding for new construction, acquisition, or rehabilitation of housing to assist very low-income adults with serious mental illness. Below is the allocation chart used for FY2006.

	Housing Related Assistance	LB40A One Time Funding	Total FY2006 Allocations	Percentage
1	\$88,100	\$97,785	\$185,885	5.0%
2	\$88,100	\$110,700	\$198,800	5.4%
3	\$268,600	\$239,850	\$508,450	13.7%
4	\$268,600	\$232,470	\$501,070	13.5%
5	\$444,800	\$446,490	\$891,290	24.1%
6	\$696,800	\$717,705	\$1,414,505	38.2%
Rg Total	\$1,855,000	\$1,845,000	\$3,700,000	100.0%
reserve	\$145,000			
Total fund	\$2,000,000			

The Division prepared “State Rental Assistance Transition Voucher Program Guidelines For the Implementation of the Housing Related Assistance for Adults with Serious Mental Illness” in order to implement the requirements of LB40 “in a manner consistent with and reasonably calculated to promote the purposes of the public behavioral health system enumerated in section 71-803.” Those guidelines are now posted on the HHSS web site (see <http://www.lhs.state.ne.us/beh/Housesum.htm>).

LB 551 (2005) changed provisions relating to behavioral health services in a number of ways including establishing a data and information system reporting duties for the Division of Behavioral Health Services. LB 551 requires the Division of Behavioral Health Services, in consultation with each regional behavioral health authority, to establish and maintain a data and information system for all persons receiving state-funded behavioral health services. LB 551 also requires the division to submit reports of the information to the Governor and Legislature on a quarterly basis beginning July, 2005.

LB 709 Adopt the Medicaid Reform Act (2005) provides legislative findings relating to the increased expenditures of Medicaid. Also, the Legislature finds that the Medicaid program provides essential health care and long-term coverage to low-income children, pregnant women and families, individuals with disabilities, and senior citizens serving over one in ten Nebraskans. The purpose of the act is to provide for reform of the Medicaid program and a substantive recodification of statutes relating to this program, including, but not limited to, the enactment of policies to 1) moderate the growth of Medicaid spending, 2) ensure future sustainability of the Medicaid program for Nebraska residents, 3) establish priorities and ensure flexibility in the allocation of Medicaid benefits, and 4) provide alternatives to Medicaid eligibility for Nebraska residents.

Under the Nebraska Behavioral Health Reform, the Medicaid Rehabilitation Option (MRO) claims payment function has been transferred from the Division of Behavioral Health Services to Medicaid starting July 1, 2005.

### **Part C Section II – Envisioned By State In The Future**

As noted above, Governor Mike Johanns made his State of the State address on January 15, 2004. He included statements on his vision for the future such as,

"We have worked directly with citizens who have mental illnesses and they have moved and impressed me. They are not weak people; they are not troubled people; they are people who have an illness. They merely seek understanding as they work daily toward their recovery. With treatment, many are undaunted by the burden of their illness only to be held back by a stigma that has no rightful place in our society today, yet sadly continues. It is time to open the doors and shine light on the dramatic advances in treatment."

Governor Dave Heineman, in his State of the State Address on January 26, 2005 to the Nebraska Legislature said,

"My budget provides funding to build upon the very impressive progress that has already been made toward expanding behavioral health services across our state and bringing treatment closer to home. You have brought new meaning to the lives and futures of thousands of Nebraskans who view your passage of LB1083 as a declaration of their value and an invitation to contribute to their communities."

The "Nebraska Behavioral Health Services Act" provides a vision of the mental health system in the future. The Act will eventually close the regional centers in Hastings and Norfolk to create more community-based programs for treating behavioral health disorders.

#### **Core Principles of Nebraska Behavioral Health Reform**

- Consumers will have services that better meet their needs and are closer to their families and communities
- Community services must be in place before patients are transitioned
- Acute and Secure hospital levels of care will continue to be required
- Current funding will be leveraged with Medicaid match dollars and re-invested in the appropriate community services
- Reform will happen in incremental steps

These core principles are reflected with the Nebraska Behavioral Health Services Act.

71-802 states "The purposes of the Nebraska Behavioral Health Services Act are to:

- (1) Reorganize statutes relating to the provision of publicly funded behavioral health services;
- (2) provide for the organization and administration of the public behavioral health system within the department;
- (3) rename mental health regions as behavioral health regions;
- (4) provide for the naming of regional behavioral health authorities and ongoing activities of regional governing boards;

- (5) reorganize and rename the State Mental Health Planning and Evaluation Council, the State Alcoholism and Drug Abuse Advisory Committee, and the Nebraska Advisory Commission on Compulsive Gambling and create the State Behavioral Health Council;
- (6) change and add provisions relating to development of community-based behavioral health services and funding for behavioral health services; and
- (7) authorize the closure of regional centers.

71-803 states the purposes for the Public behavioral health system.

The purposes of the public behavioral health system are to ensure:

- (1) The public safety and the health and safety of persons with behavioral health disorders;
- (2) Statewide access to behavioral health services, including, but not limited to,
  - (a) adequate availability of behavioral health professionals, programs, and facilities,
  - (b) an appropriate array of community-based services and continuum of care, and
  - (c) integration and coordination of behavioral health services with primary health care services;
- (3) High quality behavioral health services, including, but not limited to,
  - (a) services that are research-based and consumer-focused,
  - (b) services that emphasize beneficial treatment outcomes and recovery, with appropriate treatment planning, case management, community support, and consumer peer support,
  - (c) appropriate regulation of behavioral health professionals, programs, and facilities, and
  - (d) consumer involvement as a priority in all aspects of service planning and delivery; and
- (4) Cost-effective behavioral health services, including, but not limited to,
  - (a) services that are efficiently managed and supported with appropriate planning and information,
  - (b) services that emphasize prevention, early detection, and early intervention,
  - (c) services that are provided in the least restrictive environment consistent with the consumer's clinical diagnosis and plan of treatment, and
  - (d) funding that is fully integrated and allocated to support the consumer and his or her plan of treatment.

#### ASAM & MEDICAID

Division of Behavioral Health Services and Medicaid adopted "American Society of Addiction Medicine" (ASAM) Standards for use in the implementation of the 1915B Waiver for Adult Substance Abuse services. The "ASAM Patient Placement Criteria for the Treatment of Substance-Related Disorders" (2001) is a clinical guide used for matching patients to appropriate levels of care. The criteria reflect a clinical consensus of adult and adolescent treatment specialist that incorporate field review comments. The purpose of the criteria is to enhance the use of multidimensional assessments in making objective patient placement decisions for various levels of care. There are adult patient placement criteria and adolescent patient placement

criteria. This is part of the appropriate development of services to address “co-occurring mental and substance-related disorders”, consistent with the Diagnostic and Statistical Manual of Mental Disorders.

### **Areas needing particular attention**

#### For the Child and Adult Plans

#### Federal Requirements / Part C SECTION II

- strengths/weaknesses of the service system
- analysis of unmet service needs/gaps ... note source of information ...

### **Strengths Of The Service System**

Most of this document outlines the strengths of the State of Nebraska Behavioral Health System. Some of the key points include:

- The Governor and Legislative support for Nebraska’s Behavioral Health Reform
- There is an established system of community mental health services dating back to 1974.

### **Weaknesses Of The Service System – Analysis Of Unmet Service Needs/Gaps**

The analysis of unmet service needs and gaps presented in this section represents an overview of the weaknesses of the service system in Nebraska.

### **GAP #1: THE PREVALENCE OF MENTAL ILLNESS AND NUMBER OF INDIVIDUALS SERVED BY SYSTEM.**

The prevalence of mental illness is the estimated total number of cases of a disease in a given population at a specific time. The penetration rate is the number of individuals with these diseases being served by the public and private sectors in Nebraska. The data presented below uses the Nebraska Implementation Report 2004 for the Federal Uniform Reporting System.

	Table 1	table 2A	table 14
		Total	Total (SED)
Children			
0-3 Years		179	84
4-12 years		595	37
13-17 years		1,002	152
Total Children	22,146	1,776	273
Adults			Total (SMI)
18-20 years		1,062	231
21-64 years		15,014	6,336
65-74 years		342	176
75+ years		195	71
Total Adults	70,480	16,613	6,814
Not Available		7	2
Total		18,396	7089

SMI – Adults with Serious Mental Illness  
SED – Children with Serious Emotional Disturbances

- Table 1 (to be reported in December 2005) – The Federal Center for Mental Health Services estimated for 2004 that Nebraska has 70,480 adults with serious mental illness and 22,146 Children with Serious Emotional Disturbances. Source: State Data Infrastructure Coordinating Center, National Association of State Mental Health Program Directors Research Institute, Inc. (NRI) under contract with the Federal Center for Mental Health Services (CMHS) (contract no. 280-99-0504) August 2005. <http://www.nri-inc.org/SDICC/SDICC05/05files.cfm>
- Table 2A. Profile of Persons Served, All Programs by Age, Gender and Race/Ethnicity Unduplicated data using all Magellan Behavioral Health (MH, SA, Dual) and AIMS (Regional Centers). AIMS means Advanced Institutional Management Systems; state fiscal year (July 1, 2003 to June 30, 2004); services in programs provided or funded by the state mental health agency (HHS Division of Behavioral Health Services); all institutional and community services; The Adult data do not include Medicaid or any other publicly funded behavioral health services; the Children data do not include the services provided by the HHS Protection and Safety nor Medicaid.
- Table 14A. Profile of Persons with SMI/SED served by Age, Gender and Race/Ethnicity: Table 14 uses the same data as Table 2A, sorted by SMI and SED; SMI includes - Axis I Diagnosis 295 to 298.9 AND Axis V less than 60 (GAF SCORE); SED Axis I of 295 through 298.9 only - no other criteria other than age less 18 yrs.

Regarding Children, services in the public system are primarily available to specific target groups, including children who are state wards, children who are involved in the legal system, and children with families with no insurance or financial resources. This gap in service exists primarily because the need is great and funding resources are limited. Therefore, funds have been targeted to provide services for very specific groups of children and their families. Unfortunately, one way to access services for children is for parents to relinquish custody of their children, deeming them state wards, and making them eligible for services. Another circumstance is allowing children to fail to the point where they violate the law. Children then fall into one of the designated service categories and are able to access services. This is not an acceptable state of affairs. Appropriate service models are effective and available, but without adequate funding to serve children in need, Nebraska will continue to pay the price later by forcing children into higher levels of care and/or into the legal system.

Unfortunately, Nebraska does not have the capacity to determine the penetration rate of all systems for children with serious emotional disturbance. Because a number of systems (Nebraska Behavioral Health System, Medicaid, Office of Protection and Safety, including child welfare and Juvenile Justice, Education and Corrections) may provide some sort of mental health service for children with SED and their families, it is difficult to gather data as to an unduplicated count of children receiving services. An information system is not available which is able to synthesize data on children receiving services across multiple systems; data is not available on the number of children not receiving services. Given the anecdotal data which

indicates a large number of children needing services are not receiving them, one might theorize that some populations of children may be “over-served” while others remain unserved because they are outside the eligibility boundaries of child serving systems with adequate funding for mental health care.

The Nebraska Behavioral Health System (NBHS) is the publicly funded, non-Medicaid program. Calculation of the penetration rate is limited to those served within NBHS and reported on the Magellan Behavioral Health Information System. The penetration rate should be the number of children with this diagnosis receiving services through the Nebraska Behavioral Health System (NBHS), Office of Protection and Safety System, including Child Welfare and Juvenile Justice Systems, and others receiving services funded by Medicaid or private insurance. Most significantly, the lack of complete penetration data makes it difficult to plan for services for children when the gaps are not readily apparent.

Regarding Adults, in looking at these figures, it is important to remember that the persons served data from FY2004 is limited to the Nebraska Behavioral Health System (NBHS). NBHS is the publicly funded, non-Medicaid program. It is also important to remember the role of Medicaid, the Criminal Justice System, the private sector (health insurance and self pay) and other related areas in addressing the needs of these populations. Thus the gap here involves two areas:

1. Nebraska’s capacity to determine the Prevalence and Penetration rate for adults with mental illness.
2. The gap between the actual number of persons in need (prevalence) and the NBHS capacity to meet these needs (penetration rate).

**SOURCE:**

- On May 10, 2005, the State Advisory Committee on Mental Health Services reviewed and discussed the Unmet Needs/gaps to be included in 2006 MH Block Grant Application.
- Reviewed with the State Advisory Committee on Mental Health Services on 8/19/2004.
- URS Table 1. Profile of the State Population by Diagnosis [The U.S. Department of Health & Human Services, Substance Abuse & Mental Health Services Administration (SAMHSA), Center for Mental Health Services (CMHS); e-mail from Ron Manderscheid, 8/13/2004].
- URS Table 2A. Profile of Persons Served, All Programs by Age, Gender and Race/Ethnicity
- Table 14A. Profile of Persons with SMI/SED served by Age, Gender and Race/Ethnicity

**GAP #2:**

**DEVELOPMENTALLY APPROPRIATE SERVICES FOR YOUTH IN TRANSITION**

Additional assessment of the ability of adult providers to work successfully with transitioning is needed to ensure developmental appropriateness of services. Survey of NBHS providers indicates that traditional adult providers are often unable to efficiently serve younger adults as their developmental needs are different than older adults, and/or should be met in a different manner than older adults’ needs. The Behavioral Health Services Division provides funding for youth in transition to adult mental health services through an age waiver program (for children 17 and 18) allowing youth to access appropriate adult services that are traditionally unavailable to transition-aged youth. The burden is on the provider to communicate and provide a

developmentally appropriate adaptation of the service to the transition-aged youth. Nebraska Behavioral Health System data indicates that 12 Mental Health age waivers were requested to authorize services for youth ages 17 & 18 who were unable to be served in youth systems. Finally, while some excellent services are available, Nebraska lacks evidence-based and family-centered services, particularly for some of our most challenging populations including youth with co-occurring substance abuse and emotional disorders, transition-aged youth, and young children from birth through age five.

There are few services that provide the coordinated effort to help youth with this transition. If the family is not able to access resources and provide financial assistance for the young adult, then the youth is left with few to no resources or does not have a clue how to access those that do exist. It is also a problem for the family in the effort to help their youth of transitional age because the legal age factors into the equation and parents no longer have any rights to help their adult youth.

- Source: NBHS Annual Age Waiver Summary; 2004 Children's State Infrastructure Grant Application:

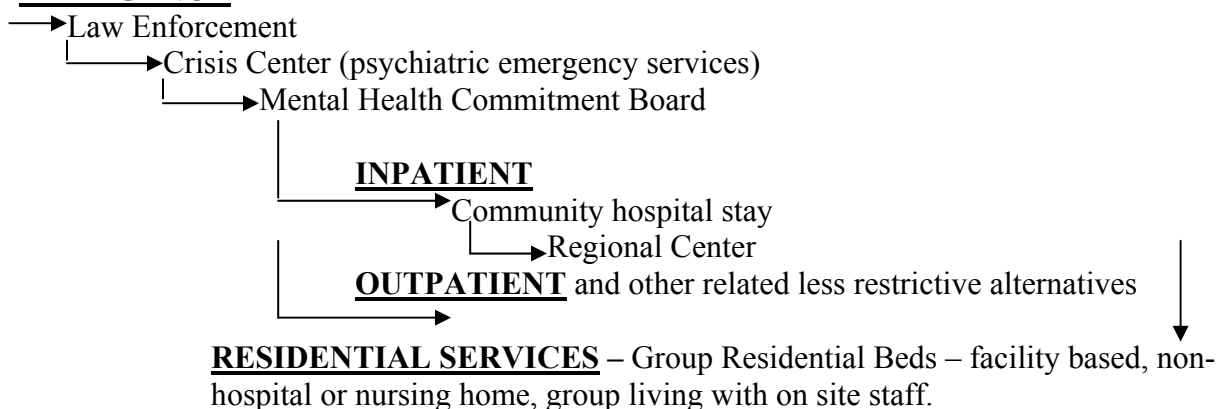
### **GAP #3: CONTINUE TO IMPROVE "STEP DOWN" SERVICES**

This is looking at the "consumer flow" of adults through only the emergency psychiatric system of the Nebraska Behavioral Health System (NBHS). This flow starts with the individual going to psychiatric emergency services, into inpatient for treatment, followed by lower levels of care suitable for the consumer's needs. There are a number of problems triggering this gap. Many involve the fragmented behavioral health system in Nebraska. There are a number of different funding streams such as Medicaid, NBHS, Protection & Safety, and private health insurance. Each funding stream has its own clinical and financial eligibility requirements. The funding levels do not provide enough incentives for individuals to select mental health as a career, leading to staffing shortages (see gap #5).

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## **MENTAL HEALTH AND SUBSTANCE ABUSE -- CONSUMER FLOW**

### **EMERGENCY**



### **NON-RESIDENTIAL MENTAL HEALTH & SUBSTANCE ABUSE SERVICES**

Housing - Independent Living in Residential Units (apartments, single room occupancy) that are affordable, decent, safe, and appropriate for people who are extremely low income with

SMI with community mental health support services; Employment services (competitive employment, integrated w/ treatment, based on consumer choice & follow-along supports).

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These problems lead to a focus on public safety issues being a priority. Areas such as psychiatric emergency services are addressed. However, there are many problems here. Richard Young Center, a psychiatric inpatient facility in Omaha, closed by April 2003. The beds had been used to serve unstable or suicidal patients. The closing of Richard Young eliminated 34 percent of Omaha's inpatient mental health beds, exacerbating the current problems.

The front end of the cycle is triggered when there is not enough housing that is affordable, decent, safe, and appropriate for people who are extremely low income with serious mental illness. Housing problems for people with serious mental illness lead to increased demand for emergency psychiatric services, increased length of stay in inpatient psychiatric services, and homelessness.

LB 40 (2005) amended Neb. Rev. Stat. § 71-812 (Behavioral Health Services Fund) to authorize the use of state funds to provide Housing-related assistance for very low-income adults with serious mental illness. LB40A also provided one-time funds for for new construction, acquisition, or rehabilitation of housing to assist very low-income adults with serious mental illness. These resources should help to address the need for housing in community settings that is affordable, decent, safe, and appropriate for people who are extremely low income with serious mental illness. With this housing, an adequate supply of the lower levels of care for mental health services needs to be included.

Progress is being made to improve the mental health community based services needed in order to address this gap and reduce the demand for Regional Center services. See ADULT GOAL #1: BEHAVIORAL HEALTH IMPLEMENTATION PLAN for the development of new services. The information was reported to the Behavioral Health Oversight Commission of the Legislature (Neb. Rev. Stat. 71-818). The Nebraska Behavioral Health Reform initiatives are helping to reduce this gap.

**SOURCE:**

- Division of Behavioral Health Services reports to the Behavioral Health Oversight Commission (monthly reports in 2005)
- On May 10, 2005, the State Advisory Committee on Mental Health Services reviewed and discussed the Unmet Needs/gaps to be included in 2006 MH Block Grant Application.
- Reviewed with the State Advisory Committee on Mental Health Services on 8//19/2004.
- Nebraska Mental Health Planning and Evaluation Council meeting on August 8, 2003.
- "Nebraska Mental Health Housing Coalition Planning Meeting" held on January 29, 2002.

#### **GAP #4: INFORMATION SYSTEM IMPROVEMENT**

There is a continuing need to work on improving the management information systems used by the Nebraska Division of Behavioral Health Services. At minimum, there is a need to check for accuracy and provide feedback on data quality. Also, work needs to be done on reporting the data collected. NBHS, Medicaid and the Regional Centers each have their own data systems. Also, Federal Medicaid and the Federal Center for Mental Health Services have different reporting requirements. Solutions to those problems are left to the states to resolve. In general, the data needs to be used to answer questions such as “who are we serving?” “What services are they getting?” and “What results were produced?” As a result, there are various problems.

Under the Nebraska Behavioral Health Services Act, § 71-806 the duties of the Division of Behavioral Health Services are listed. The duties include (1)(e) “development and management of data and information systems”. Then, as noted above, LB 551 (2005) sets legislative requirements for data and information system reporting duties for the Division of Behavioral Health Services. LB551 also requires the information to be reported to the Governor and Legislature on a quarterly basis beginning July, 2005.

HHSS continues to improve the data infrastructure to improve the capacity for data collection and reporting. For example, the AVATAR software is ready for the implementation in July 2005 at the Lincoln Regional Center. The AVATAR software is HIPAA compliant. The AIMS system will operate in parallel to AVATAR for several months following implementation. During the transitional period double entries will be done by the Regional Center staff to maintain both systems. The advantage of AVATAR is that it would provide electronic patient records and billing and reduce possible errors. The Policy Cabinet approved the implementation of the AVATAR software and the July 2005 go-live date.

Magellan Behavioral Health ASO services contract covering Nebraska Behavioral Health System (NBHS) information system was recently approved for a three year extension by the Nebraska Health and Human Services Policy Cabinet, covering FY2006, FY2007 and FY2008.

#### **REGIONAL CENTER DISCHARGE FOLLOW-UP SERVICES**

The Division has contracted with the University of Nebraska Medical Center (UNMC) Preventive and Societal Medicine. The purpose of the contract is to follow adult patients (age 18 years and older) who were discharged from regional centers starting January 1, 2005 using Nebraska Health and Human Services data. Using the data, UNMC will prepare monthly, annual, and ad hoc reports on the status of these discharged patients. The term of this Contract is from March 1, 2005 through May 31, 2006. The Objectives of the contract are

1. Develop a system to monitor the status of the patients released from regional centers. Included Regional Center Populations are adults (age 18 and older) who are served within the Regional Center Units to be downsized at Hastings and Norfolk as well as the Lincoln Regional Center Short Term Care Unit and Community Transition Program.
2. Create monthly, summary system, and ad-hoc reports based on information collected through the monitoring system.
3. Develop the reporting capacity for Federal Uniform Reporting System Tables 20 A and 20 B.

## CONSUMER SURVEY DATA COLLECTION

Nebraska Department of Health and Human Services, Division of Behavioral Health Services and the Nebraska Department of Health and Human Services Regulation and Licensure, Public Health Assurance (R&L) signed an interagency agreement to collect the consumer survey data needed for the Federal Uniform Reporting System Table 11. R&L is the State Public Health Agency responsible for conducting state annual Behavioral Risk Factor Surveillance System (BRFSS) telephone survey. This survey is supported by the Centers for Disease Control (CDC).

Under the agreement, the Division of Behavioral Health Services provided the questionnaire and cover letter. The Division also provided an electronic file (in Excel) of 5,000 names, addresses, and other related information. In April 2005, the Division provided the consumer to be contacted: Dual - 17 - Children and 138 – Adults; Mental Health - 463 - Children and 2,238 – Adults; Substance Abuse - 147 Children and 2,500 – Adults; for the following totals - children - 628 and 4,872 Adults (5,500). The Division is also responsible to arrange for data analysis to be completed.

Under the agreement, R&L translated the survey materials provided into Spanish, sent a letter to the consumers receiving the survey to introduce the survey, explains the need, how the consumer will be contacted by phone at a specific number sometime over the next few weeks. The letter provides the consumer with an opportunity to indicate (a) wrong number to reach them, (b) do not call me, but send me a questionnaire or (c) do not call or send me anything (decline participation). A toll free number (1-877-791-7359) was provided to have the consumer call R&L to provide the corrected phone number, to request a mail survey, or to decline participation. If the consumer does nothing, it served as a form of consent to participate on the survey. R&L is authorized to call the listed phone number. The surveys are to be completed by September 29, 2005. The same process for this Behavioral Health survey is being used as the Nebraska Behavioral Risk Factor Surveys (BRFS) samples.

## SOURCE:

- Nebraska Division of Behavioral Health Services
- HHSS Policy Cabinet Minutes; April 26, 2005; Implementation of AVATAR Software at the Lincoln Regional Center

## **GAP #5: SHORTAGE OF STAFF**

There is a critical shortage of qualified Nebraska Behavioral Health Staff for providing treatment, rehabilitation and support services as well as handling administrative functions. The shortage of credential staff includes psychiatrists, psychologists, licensed mental health practitioners (LMHP), nurses and Alcohol/Drug Abuse Counselors. With all the increasing expectations on what the Nebraska Behavioral Health System (NBHS) needs to address, there also needs to be adequate supply of administrative personnel at all levels of operations.

In order to help address these issues, the University of Nebraska Medical Center, Health Professions Training Center (HPTC) will be completing a “Mental Health Professionals

Survey". The survey will be sent to licensed mental health professions of Psychiatrist, Psychologist, Licensed Mental Health Practitioner (LMHP), and Licensed Alcohol/Drug Abuse Counselor (LADAC). Registered Nurses will be covered in a separate survey. The survey will be asking questions on the professionals educational background, whether or not the person is actively seeing patients, the practice locations, a biosecurity assessment (training needs / training skills), and related areas.

Mental Health Professional Shortage Areas (MHPSAs) (page 39; 2003 Databook)

In 2003, the U.S. Department of Health and Human Services designated over 90 percent of Nebraska's counties (88 of 93) as MHPSAs. Based on 2000 census data, the population within these shortage areas (N = 1,045,809) exceeds 61 percent of the state's total population. Several other facilities serving low income and institutionalized populations are also designated.

The data below is the current supply of Nebraska Psychiatric Professionals, based on their primary practice locations, as of June 2005, according to the University of Nebraska Medical Center's Health Professions Tracking Center.

PSYCHIATRIC SHORTAGE AREAS In Nebraska, Psychiatric Professionals, Primary Practice Locations (July 2005):

Region	Psychiatry		Child / Adol. Psychiatry		Nurse Practitioners		Physician Assistants		Totals	
	#	%	#	%	#	%	#	%	#	%
1	4	3%	1	5%	2	10%	0	0%	7	4%
2	2	2%	2	10%	2	10%	0	0%	6	3%
3	10	8%	2	10%	7	35%	0	0%	19	11%
4	10	8%	1	5%	0	0%	2	40%	13	8%
5	24	19%	3	14%	7	35%	2	40%	36	21%
6	59	46%	17	81%	10	50%	3	60%	89	51%
Totals	127	100%	21	100%	20	100%	5	100%	173	100%

Health Professional Shortage Areas (page 40; 2003 Databook)

- Federally Designated Psychiatric Shortage Areas – 88 of 93 Nebraska Counties. The Omaha Metro Area / Region 6 are excluded. All other Nebraska counties are designated as "Psychiatric" shortage areas
- State Designated Psychiatric Shortage Areas – 87 of 93 Nebraska Counties with State Designated Shortage Areas - "Psychiatric" shortage areas. The six not designated were Buffalo, Dakota, Douglas, Lancaster, Sarpy, Scotts Bluff counties.

According to the Mental Health Care Professionals (page 41; 2003 Databook), there are Psychiatrists (140), Psychologists (330), Master Social Workers (610), Certified Professional Counselors (760), Licensed Mental Health Practitioners (1,795) and Certified Marriage and Family Therapists (76).

Nurse Shortage Counties - In nursing, 37 of 93 Nebraska's counties are considered to have a shortage, as of 11/04/02. The list of "Nursing Shortage County" is from the U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions, Division of Nursing <<http://bhpr.hrsa.gov/nursing/shortage.htm#ne>>.

Lack Of Expertise Available To Work With Persons With Dual Disorders

Substance abuse and dependence may go undiagnosed and untreated in adults with serious mental illness and children with serious emotional disturbance. Assessing substance abuse disorders is a key issue here.

This is especially a problem for children with serious emotional disturbance. All of the Nebraska Behavioral Health Regions throughout the state of Nebraska have expressed the need for more qualified staff and professionals, more specialized training for all non mental health staff and professionals who work with children diagnosed with a dual disorder (mental health and substance dependence). There is a need to expand services in order to serve more youth in rural and frontier areas. Treatment professionals and educators, as well as parents in Nebraska would benefit from more education and training to assess and refer children for dual disorder treatment, and earlier intervention and assessment services. Furthermore, the need for more cooperation and communication between the mental health and substance abuse treatment systems, as well as other child serving systems.

LB1083 (2004) sections 103 – 125 amended the Uniform Licensing Law and the Requirements for Certified Alcohol/Drug Abuse Counselors (CADAC). As a result, there are now the following levels of certification: Licensed Alcohol/Drug Abuse Counselor (LADAC); Licensed Provisional Alcohol/Drug Abuse Counselor (LPADAC); and Licensed Provisional and Licensed Mental Health Professionals Special Provisions.

The following comments were made by Donald E. Fischer, MD, DABFM, C.A.S.A.M, psychiatrist and medical addictionist, in private practice, Scottsbluff, NE and former Member of the MHPEC Executive Committee (8/05/2003) He said the average physician without any special training or clinical experience may be able to diagnosis alcohol (and other) dependencies but not be prepared to recommend the level of treatment needed, depending on patient age, chronicity, prior treatment outcome, support system, and related areas. Therefore, additional training is usually needed. The same goes for a licensed psychologist without specific training in addictive and compulsive disorders. CADACs are not qualified to go beyond basic substance dependence assessment. By training and licensure they are not qualified to recognize comorbid disorders such as Bipolar disorders, ADDH, OCD and other anxiety disorders, Axis II disorders, etc. Medical conditions accompanying substance dependence are beyond their purview, as well as the role of psychoactive medications (both dependency-producing and those needed in treatment, i.e.: antidepressants).

Mental health is chronically under funded. To address the staffing issues, models of care must be adopted that allow the system to use the available expertise to the greatest extent possible. For example, general practice physicians, advanced practice nurses, and physician's assistants

may be able to fill the roles of psychiatrists. In non-medical areas Licensed Mental Health Practitioners and Psychologists have filled traditional therapy roles. The use of physician extenders, non-physician program directors with psychiatric consultation, shared consumer management duties with other professions, and consultation over the internet are but a few of the ways that psychiatric expertise can be used.

Blaine Shaffer, MD (Chief Clinical Officer for the Division of Behavioral Health Services) commented on the shortage of psychiatrists in Nebraska. He said, "The point is that we need psychiatrists, not others acting as psychiatrists. One issue involved in medical students not choosing psychiatry is their perception that you don't have to be a trained psychiatrist to do psychiatry. Physician extenders are very helpful but should not replace psychiatrists. "Telepsychiatry could be a way for psychiatrists and other providers to collaborate and provide quality care for people in shortage areas. This modality is also currently underfunded."

For more information on the federal Health Professional Shortage Area status contact Thomas Rauner in the HHS Office of Rural Health and Primary Care (402-471-0148).

**SOURCE:**

- University of Nebraska Medical Center, Health Professions Tracking Center, July 2005
- Reviewed with the State Advisory Committee on Mental Health Services on 8/19/2004, 5/10/2005 and 8/9/2005 as well as the NE Mental Health Planning and Evaluation Council meetings on August 16, 2001, February 4, 2002, and August 8, 2003.
- The Nebraska Health Information Project: 2003 Databook. (2003). Nebraska Center for Rural Health Research, University of Nebraska Medical Center.
- Blaine Shaffer, MD
- "Rural Mental Health Aid Sparse" Lincoln Journal Star; Tuesday July 1, 2003
- Nebraska HHS Office of Rural Health & Primary Care (July 2005.) This office has the responsibility to review (and submit if appropriate) federal shortage area applications to the Shortage Designation Branch, including the Psychiatric Health Professional Shortage Area.
- U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions, Div. of Nursing  
<<http://bhpr.hrsa.gov/nursing/shortage.htm#ne>>

**GAP #6: MEDICATION ACCESS**

This gap involves many things related to providing access to psychiatric medications for persons with serious mental illness or youth with serious emotional disturbance. Without access to medication, people with mental illness may stop taking the treatment. That leads to an increase in the likelihood of a serious episode, resulting in emergency room visits, in-patient hospitalization, and crisis services. One of the SAMHSA Evidence-Based Practices (EBP) is Medication Management. It involves the systematic use of medications as a part of the treatment for schizophrenia. For more information see <<http://www.mentalhealthpractices.org/se.html>>.

This is from the MHPEC Strategic Planning meeting on April 12, 2002.

- "Medication Access" is an issue because:

- there is not a stable reliable source of medications for people with mental illness.
- no clear cut mandate on who is to pay for what. Everyone wants to be the one who pays last dollar.
- "Medication Access" Theme: Reducing the barriers to getting the right drug to the right recipient in the right dosage by the right route at the right time to consumers in community mental health settings.

There are many groups involved in this medication access issue ranging from

1. Consumers, family members
  2. County Level Services: Counties, County Attorneys, Mental Health Commitment Boards, Sheriffs (transportation), Veteran Service Center, County Corrections
  3. Service Providers: Regional Centers, Community Mental Health providers, Emergency Care Centers, Housing providers; Pharmacies, Physicians, and other health care practitioners, Nebraska Medical Association's mental health task force, Regional Governing Boards, Law enforcement, Corrections ...
  4. Payers: Medicaid, Medicare, Managed Care Companies, Private insurance companies, SSI, SSDI, and Nebraska Department of Health and Human Services.
  5. Resources: Drug companies, Pharmacies ...
  6. Advocates / allies: Nebraska Association of Behavioral Health Organizations (NABHO), National Alliance for the Mentally Ill-Nebraska (NAMI-NE), and Mental Health Associations of Nebraska.
- LB 1148 (2002) PRESCRIPTION DRUG ASSISTANCE required the Health and Human Services Committee, on or before December 1, 2002, to conduct research and provide recommendations to the Nebraska Legislature and the Governor on the topic of prescription drug assistance. The bill required the committee to consult with members of the Legislature, the Governor, the Nebraska Health and Human Services System, the Department of Insurance, the Department of Revenue, political subdivisions, area agencies on aging, pharmacists, pharmaceutical manufacturers, advocates for the elderly and persons with mental illness, health care providers, insurance companies, and other interested parties.
  - Summary on Medication Support Oriented Comments from the "ACCESS TASK FORCE" Forum held on January 20, 2000 in Omaha by the Nebraska Mental Health Planning and Evaluation Council (MHPEC).
    - Many times know someone needs to get into hospital, but are not yet to the crisis level of MI & Dangerous. If not eligible for Medicaid or Medicare, it is real hard to get money for the medications. If you can get the medications you can prevent the need for the hospital bed.
    - substance abuse is self medication ... abuse and violence may come with it.
    - access to insurance company - need 20 phone call to get care ... a barrier to services
    - working poor - person is not eligible for Medicaid because they work but do not earn enough to pay for the medication. With Medicaid you can usually find someone who can take care of the individual ... the working poor need some mechanism to access the care.
    - One person testified he was on 8 different medications in last 15 years.

- Trouble in rural NE not the same in urban NE ... shortage of psychiatrists.

Trish Blakely, Healthy Families (August 11, 2004): "It is also a tremendous problem trying to locate a psychiatrist to prescribe medication. There seems to be a very long waiting period to see a psychiatrist. Families have little selection about whom they see due to the choices available and if there is a crisis situation there is little probability that they will be able to reach a psychiatrist to get assistance. This happens over and over with families in Healthy Families Project and the Family Resource Center."

Nebraska is paying for medications. Here are examples:

- One source to pay for psychiatric medications is "LB95". This is an indigent outpatient, prescription medicine program administered by the Department of Health and Human Services. It is authorized under Neb. Rev. Stat. §83-380.01 (Laws 1981, LB 95, § 25). The authorized consumer is indigent, receiving outpatient medications, and has a history of Board of Mental Health commitment to inpatient or outpatient levels of care. In FY2003 the Nebraska Office of Mental Health, Substance Abuse And Addiction Services", paid \$600,000 for "Indigent Medications". The Community Mental Health Funding via the Division of Behavioral Health Services line item "Indigent Medications" (through Regional Centers) was \$2,000,000 in FY2004. 752 Consumers have received medication from Nebraska Regional Centers (as of December 21, 2004.)
- The administrator for the Division of Behavioral Health Services held a meeting on March 11<sup>th</sup>, 2005 to discuss the intricacies, issues, and process for accessing medication through LB95 funds and the pharmacies at the Regional Centers. The meeting began the process for improving the utilization of medication funds in Nebraska. Information from this meeting has been utilized to write draft regulations for the *Provision of Prescription Medicine Necessary for Mental Health Treatment to Indigent Person Receiving Outpatient Services who has Received MHB Ordered Treatment* and will involve the creation of a workgroup to manage utilization of LB95 services. The LB95 utilization group will look at the possibility of a common formulary for LB95 medications; distribution of medications through local pharmacies, such as Walgreens; and identifying a mechanism for utilization of newer medications.
- Nebraska belongs to the Minnesota Multi-State Contracting Alliance for Pharmacy which is a purchasing organization that allows the State to acquire medications at a reduced rate.
- The National Association of State Mental Health Program Directors collects "Mental Health Expenditures and Revenues report" annually. For 2003, Nebraska reported total expenditures for psychiatric medications as \$72,923,396.

#### **FY 2003 Expenditures for Psychiatric Medications and "Atypical" Antipsychotics**

	State Psych Hospitals	Medicaid	LB95	Total
Atypical Antipsychotics	NA	\$28,348,305	NA	\$28,348,305
All Other Medications	NA	\$40,075,902	NA	\$40,075,902
Both	\$3,899,189		\$600,000	
TOTAL PHARMACY	\$3,899,189	\$68,424,207	\$600,000	\$72,923,396

NA = Services provided but exact expenditures not available.

To the nearest \$100,000 / Prepared December 2004

## **SOURCE**

- Reviewed with the State Advisory Committee on Mental Health Services on 8/19/2004, 5/10/2005 and 8/9/2005.
- HHSS financial data on as of 06/30/03, Agency 025 HHS SYSTEM – SERVICES; 361 Program HASTINGS REG CENTER; 362 Program NORFOLK REG CENTER; 363 Program LINCOLN REG CENTER; “LB95” indigent outpatient prescription medicine program administered by the Department of Health and Human Services authorized under Neb. Rev. Stat. §83-380.01; and Medicaid expenditures psychiatric medications in FY 2003 Expenditures for Psychiatric Medications from Kim Collins, HHS Services, Financial Services, Financial & Program Analysis, 12/15/2004.
- Nebraska Mental Health Planning and Evaluation Council meeting on August 8, 2003.
- Medication Accessibility discussed at the Mental Health Planning & Evaluation Council Strategic Planning Meeting - April 12th, 2002.
- Mental Health Planning & Evaluation Council June 14th, 2002 Videoconference Meeting
  - report from April 12 Strategic Planning meeting
  - Jeff Santema, Legal Counsel, Health and Human Services Committee, Nebraska Legislature: Report on Legislative Interim Studies pertinent to mental health
- ACCESS TASK FORCE" Forum held on January 20, 2000 in Omaha by the Nebraska Mental Health Planning and Evaluation Council (MHPEC).

## **GAP # 7: CULTURALLY COMPETENT SERVICES**

In 2004 a critical service gap in the adult and children’s mental health system was identified to be cultural and linguistically competent services. A language barrier was reported in several communities across Nebraska both rural and urban, due to the increase in minority populations living across the state. In 2005 these barriers continue to be a problem as the service gaps have not been addressed.

This gap in mental health care was first identified nationally in 1999 by the Surgeon General who addressed disparity as lying in the availability, accessibility, and quality of mental health services for racial and ethnic minorities. The Surgeon General made it clear that these disparities result in ethnic and racial minorities bearing a disproportionately high disability burden from mental disorders. The Surgeon General also identified the lack of information regarding the mental health needs of many racial and ethnic minorities as adding to the critical disparity. As part of the challenge to the nation the Surgeon General released *Healthy People 2010* in early 2000 to address disparities in health care access and outcome.

In December 2000, the Office of Minority Health, U.S. Department of Health and Human Services, published final recommendations on national standards for culturally and linguistically appropriate services in health care. These are meant to be a blueprint for federal and state health agencies, policy makers, and national organizations to build culturally competent health care organizations and workers.

Sadly, Nebraska continues to lag behind in implementation of the Cultural and Linguistic Appropriate Services (CLAS) which could facilitate the closing of this gap. On February 8, 2005 the State Advisory Committee on Mental Health Services first addressed cultural competence goals and objectives. Dr. Maria Prendes-Lintel presented on the fourteen Cultural and Linguistic Appropriate Services (CLAS). These CLAS were identified and members of the committee were asked whether their agencies were in compliance with these standards particularly those that are federally mandated. The lack of resources and complexity in addressing these gaps was discussed as well as the cost and complexity of not addressing these needs. The importance of having competent and trained interpreters was highlighted. The impact of the language barrier was addressed as one of the most critical gaps affecting access, delivery and viable use of mental health services. One way this disparity can begin to be addressed in Nebraska is for the Behavioral Health Council that oversees the Mental Health, Gamblers and Substance Abuse committees to develop a subcommittee to address the cultural competency of those providing services. It is a goal in the future to close this gap and report progress in this area.

Tanya D. Cook, Governor's Director of Urban Affairs and Manager, Office of Minority Health noted a need to work with Sudanese and Somali Bantu refugees. They have unique mental health challenges due to conflicts in their home countries and refugee camps; how issues are handled within family structure and less likely to seek outside help.

Jackie Miller, HHS Deputy Director Health Services noted the following, "Domestic violence is the norm in Sudanese households. In addition the women are not allowed to speak when interviewed, etc----the men speak for the women. For those women who do break away and get help, the family unit is completely destroyed. The father loses the respect of his children----as he is unable to keep his wife under thumb (especially if she ends up in a shelter). The children also despise the mother in such cases."

Jose J. Soto said, "Despite the rapid growth of the Hispanic/Latino population in our rural communities, public sector response to the mental and behavior health service needs of that population have been slow to come and not commensurate with the growth, verified needs and often dire circumstances of this population. Included in the latter are the harsh realities of chronic poverty, the lack of adequate and stable medical care, cultural isolation, racism, and quite frequently language barriers that make available services effectively inaccessible."

It should be noted that the Division of Behavioral Health funds mental health services for the four federally recognized tribes of Nebraska (Ponca, Winnebago, Omaha, & Santee). The FY2006 contracts with the four tribes totals \$503,928 for mental health services. The data presented below uses the Nebraska Implementation Report 2004 for the Federal Uniform Reporting System.

<b>Table 2A. Profile of Persons Served, All Programs by Age, Gender and Race/Ethnicity</b>								
	American Indian or Alaska Native	Asian	Black or African American	Native Hawaiian or Other Pacific Islander	White	More Than One Race Reported	Race Not Available	Total
Total	536	68	807	10	14,732	1,284	959	18,396
% of total	2.9%	0.4%	4.4%	0.1%	80.1%	7.0%	5.2%	100.0%

## Race / Nebraska 2000 State Census Profile

	American Indian or Alaska Native	Asian	Black or African American	Native Hawaiian or Other Pacific Islander	White	More Than One Race Reported	Race Not Available	Total
Total population	22,204	26,809	75,833	1,733	1,554,164	55,996		1,736,739
% of Total	1.3%	1.5%	4.4%	0.1%	89.5%	3.2%		100.0%

The data presented below uses the Nebraska Implementation Report 2004 for the Federal Uniform Reporting System.

<b>Table 2B. Profile of Persons Served, All Programs by Age, Gender and Race/Ethnicity</b>				
	Not Hispanic or Latino	Hispanic or Latino	Hispanic or Latino Origin Not Available	total
Total	16,516	938	942	18,396
% of total	89.8%	5.1%	5.1%	100.0%
Total Nebraska population		1,711,263	100%	
Total Hispanic or Latino (of any race)		94,425	5.5%	

The race and ethnicity data are as reported on Nebraska 2000 State Census Profile, Nebraska Department of Economic Development web site. <http://info.neded.org/neprof00.htm>

## Sources:

- Jose J. Soto, Vice President for AA/Equity/Diversity, Southeast Community College Area, Lincoln, NE; July 2, 2004; email to the six Regional Program Administrators Subject; Unmet Mental Health Needs.
- State Advisory Committee on Mental Health Services: Cultural Competence Goals and Objectives. February 8, 2004. Presented by Maria Prendes-Lintel, Ph.D. Licensed Psychologist, Executive Director FIRST Project; and written text 7/22/2005.
- State Advisory Committee on Mental Health Services meeting 5/10/2005 & 8/9/2005.
- Surgeon General's Report, 1999 Mental Health: Culture, Race, Ethnicity. SAMHSA.
- Closing the Gap. A newsletter of the Office of Minority Health, U.S. Department of Health and Human Services. February/March 2001

- Nebraska Community Mental Health Services Block Grant Implementation Report 2004; Uniform Reporting System (URS).
- Nebraska 2000 State Census Profile; Nebraska Department of Economic Development <<http://info.neded.org/neprof00.htm>>
- Division of Behavioral Health on the funding of mental health and substance abuse services for the four federally recognized tribes of Nebraska – Ponca, Winnebago, Omaha, & Santee (7/25/2005).

#### **GAP #8: ELDERLY POPULATION BEING SERVED**

Another important gap is mental health services to elders. In the Report of the Surgeon General on Mental Health, it notes that millions of older Americans—indeed, the majority—cope constructively with the physical limitations, cognitive changes, and various losses, such as bereavement, that frequently are associated with late life. However, a substantial proportion of the population 55 and older—almost 20 percent of this age group—experience specific mental disorders that are not part of “normal” aging. Research has helped differentiate mental disorders from “normal” aging. This includes depression, Alzheimer’s disease, alcohol and drug misuse and abuse, anxiety, late-life schizophrenia, and other conditions can be severely impairing, even fatal. In the United States, the rate of suicide, which is frequently a consequence of depression, is highest among older adults relative to all other age groups.

The data presented below uses the Nebraska Implementation Report 2004 for the Federal Uniform Reporting System. Table 2A shows a total number of persons served as 18,396. That means those served age 65+ represents 2.9% of the total. Table 14A shows a total number of persons served as 7,089. That means those served age 65+ represents 3.5% of the total.

Nebraska Persons Served		
	Table 2A Total	Table 14A Total
65-74 years	342	176
75+ years	195	71
Total 65+	537	247

Table 2A shows 537 people age 65+ (2.9%) out of the total persons served of 18,396. Table 2A is the “Profile of Persons Served, All Programs by Age, Gender and Race/Ethnicity”. The data is an unduplicated count of all institutional and community services using Magellan Behavioral Health (MH, SA, Dual) and AIMS (Regional Centers) for state fiscal year (July 1, 2003 to June 30, 2004). The services are provided or funded by the state mental health agency (HHS Division of Behavioral Health Services). Table 14A is a profile of Persons with SMI/SED served by Age, Gender and Race/Ethnicity. It is the same data as Table 2A, sorted by Axis I Diagnosis 295 to 298.9 AND Axis V less than 60 (GAF SCORE). Meanwhile, the Nebraska Census Data shows (2000) shows the number of people over age 65.

Nebraska Census Data shows (2000)

65 to 74 years	115,699	6.8
75 to 84 years	82,543	4.8
85 years and over	33,953	2

The State of Nebraska population total age 65+ is 232,195, which is 13.6% of the total population of 1,711,263. While overall, 18.4 percent of the state's population is comprised of people 60 and older, some counties in Nebraska have much higher rates of older citizens. The counties with the highest over 60 population are Pawnee (35 percent), Webster (33 percent), Franklin (33 percent), Furnas (33 percent), Thayer (32 percent) and Hooker (32 percent).

Source:

- Reviewed with the State Advisory Committee on Mental Health Services on 8/19/2004, 5/10/2005 and 8/9/2005.
- Nebraska FY2004 Implementation Report URS Tables 2A and 14A
- Nebraska Mental Health Planning and Evaluation Council meeting on August 8, 2003.
- web site for the Eastern Nebraska Office on Aging, Omaha, NE  
<http://www.enoa.org/demographics/index.html>
- U. S. Bureau of the Census, Census of Population, decennial, and March 2001 as reported in the "Nebraska Databook" <<http://info.neded.org/databook.php?cont=sb&ttle=Population>>
- Source: U.S. Department of Health and Human Services. Mental Health: A Report of the Surgeon General, Chapter 5: Older Adults and Mental Health; 1999.  
<http://www.surgeongeneral.gov/library/mentalhealth/home.html>

#### **GAP #9: MENTALLY ILL INMATES DISCHARGING FROM THE STATE CORRECTIONAL SYSTEM**

There is a gap in the State Behavioral Health System regarding mentally ill inmates who discharge from the Nebraska state prison system operated by the Nebraska Department of Correctional Services (DCS) into the community. Discharging inmates who are mentally ill represent a relatively large, but formerly unrecognized population. These former inmates need access to behavioral health services including psychiatric, mental health, substance abuse, and dual diagnosis treatment to address their needs.

Facility	# Intakes	Major Mental Illness*	Other Mental Illness**	Total Mental Illness***	Substance Abuse or Dependence+	Dual Diagnosis++
DEC	1,622	79—4.9%	124--7.6%	203—12.5%	NA	60—3.7%
NCYF	113	11—9.7%	20—17.7%	31—27.4%	NA	5—4.4%
NCCW	386	54—14.0%	53—13.7%	107—27.7%	NA	38—9.8%
TOTAL	2,121	144—6.8%	197—9.3%	341—16.1%	1,743-82.2%	103—4.9%

\* Defined as having a DSMIV diagnosis code between 295 and 298.9

\*\* Includes all other DSMIV diagnosis codes other than 295 through 298.9

\*\*\* Total of major mental illness and other mental illness combined

+ Substance abuse or dependence diagnoses made by substance abuse staff

- ++ Major mental illness diagnosis plus a substance abuse or substance dependence diagnosis
  - o DEC.....Diagnostic and Evaluation Center
  - o NCYF .....Nebraska Correctional Youth Facility
  - o NCCW.....Nebraska Correctional Center for Women

A growing body of literature indicates that a significant percentage of the state prison population suffers from mental illness. A commonly cited estimate is that about 16 percent of inmates in state prisons have a mental illness. The rate of mental illness among female prisoners has been estimated to be much higher; perhaps 25% or more. The rates of mental illness found in the Nebraska prison population are generally consistent with the national trends. Above is a tabulation of the rates of diagnosed mental illness by intake facility and category for the period from July 1, 2004 through June 30, 2005. The information for the majority of the table is based on diagnoses made at intake by mental health staff. However, the substance abuse and substance dependence data (column 6) is based on diagnoses made by substance abuse staff. Please note that the Diagnostic and Evaluation Center (DEC) primarily serves adult males, the Nebraska Correctional Youth Facility (NCYF) has younger offenders to age 21 years 10 months, and the Nebraska Correctional Center for Women (NCCW) serves female offenders.

Another indicator of the high rate of persons with mental illness in the prison system is the number of inmates who are prescribed psychiatric medication. The rate as of June 30, 2005 is about 20.2 percent of the inmate population which is 854 inmates. A large number of inmates who were incarcerated for committing sexual offenses are discharged from DCS each year. For example, during fiscal year 2005, 137 inmates who had committed a sexual offense were released. Of that number, 18, or 13% were recommended by DCS staff for post incarceration mental health board hearings for possible civil commitment. The chart below summarizes the number of offenders who came from each of the State Behavioral Health Regions (i.e. they were sentenced in a county in that region) and the number who were recommended for possible civil commitment.

Region	I	II	III	IV	V	VI	Totals
# Released	9	13	23	26	32	34	137
#Recommended	1	0	7	5	1	4	18

#### Jail Diversion

The Lancaster County Mental Health Jail Diversion Project (LCMHJDP) began in 2003 through grant funding from the Substance Abuse and Mental Health Services Administration (SAMHSA). This 3-year grant provides approximately \$300,000 annually in funding. Grant funding ends in 2006. The Jail Diversion Project seeks to identify potential candidates once they are booked into the Lancaster County Jail. The Project serves persons with a severe and persistent mental illness (SPMI) or co-occurring substance use disorder who have committed non-violent misdemeanor offenses.

Once a person is diverted from the jail, the Project provides multiple services with two primary goals in mind: 1-Improve the quality of life for persons served. 2-Eliminate or drastically reduce the “revolving door” in and out of the criminal justice system for persons served.

Intensive Case Managers work with the diverted person to help them meet many basic needs, such as stable housing; obtaining food, medications, dental and medical care; providing transportation to appointments and court appearances; assisting in applications for Medicaid, Medicare, General Assistance, Food Stamps, Patient Assistance Programs for free medications, etc. The Project typically works with individuals for 6 to 12 months. Beyond stabilization services, the Project also ultimately seeks to link diverted individuals into community services where they can receive long-term, less intensive, lower cost, outpatient services.

To date, the program has diverted 80 persons. The recidivism rate for this population is approximately 10%. This is compared to a recidivism rate of almost 30% for potentially mentally ill persons incarcerated in the Lancaster County Corrections system who do not receive services through the Jail Diversion Project.

Additionally, persons utilizing the Project do not use costly emergency and inpatient services, such as the crisis center, hospital emergency departments, etc. Instead, they are now stabilizing and accessing lower cost, less intensive, long-term outpatient services. Participants also boast improved self-esteem, an ability to better deal with crisis situations in their life, and drastically decreased symptomatology. For more information about the LCMHJDP, contact Travis Parker, Project Director (402- 441-6610 / <tparker@ci.lincoln.ne.us>)

sources:

- On May 10, 2005, the State Advisory Committee on Mental Health Services reviewed and discussed the Unmet Needs/gaps to be included in 2006 MH Block Grant Application. As a result of that discussion, the committee voted in favor of adding a gap statement on Mentally Ill Inmates Discharging from the State Correctional System to the FY2006 application.
- Cameron S. White, Ph.D., Behavioral Health Administrator, Nebraska Department of Correctional Services, 7/21/2005.
- Travis Parker, Project Director, Mental Health Jail Diversion Project; Community Mental Health Center of Lancaster County, Lincoln, NE; 7/07/2005.

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### **Section III. Performance Goals and Action Plans to Improve the Service System**

#### **ADULT PLAN**

Also addresses: SECTION I. Description of State Service System - areas identified by the State in the previous State plan as needing particular attention and SECTION II Service System's Strengths, Needs and Priorities.

#### **Statement of the State's priorities and plans to address unmet needs (Goals).**

#### **ADULT GOAL #1: BEHAVIORAL HEALTH IMPLEMENTATION PLAN**

##### **- Areas Identified In The Previous State Plan As Needing Particular Attention**

This was identified in the previous state plan as ADULT GOAL #1: BEHAVIORAL HEALTH IMPLEMENTATION PLAN.

- The State's Priorities And Plans To Address Unmet Needs.

This goal is to successfully implement the Nebraska's Behavioral Health Reform. Below represents a summary of key points to illustrate the work being completed under Adult Goal #1:

State Priorities: The plans and funds appropriated to the behavioral health (mental health and substance abuse) system are specifically intended to serve the adult population. On July 1, 2004, the Nebraska Health and Human Services System released the Behavioral Health Implementation Plan. The complete 208-page Behavioral Health Implementation Plan and other information regarding implementation of LB 1083 (2004) can be accessed at the HHSS website at <http://www.hhs.state.ne.us/beh/reform/>.

The following information is to demonstrate the direction the community component of the Nebraska Behavioral Health Reform is taking. For FY2006, the goal is to continue moving in this direction. Below is a progress report on the Development of Community-based Services in the six Regional Behavioral Health Authorities as presented on August 12, 2005 to the Behavioral Health Oversight Commission of the Legislature.

The plans and funds appropriated to the behavioral health (mental health and substance abuse) system are specifically intended to serve the adult population and to directly impact the following state priorities:

Phase I: Regional Center REPLACEMENT Services.

Priority A – **REPLACEMENT** services to replace current HRC/NRC acute inpatient and secure subacute residential services

Priority B – **DISCHARGE READY** services for persons currently being served in the HRC/NRC/LRC

Priority C – **EMERGENCY SERVICE** development and/or restructuring to reduce EPCs and commitments in the regions.

Phase II: Expansion of Community Based Services to Impact Reduction in Need for Acute and Secure services.

Priority A: **NON-RESIDENTIAL SERVICE** development and/or expansion to reduce use of acute inpatient and secure subacute residential services, and increase community tenure in the least restrictive setting with stable housing.

**Region I Reform Plan New Services (as of 8/5/2005)**

- Acute & Subacute Inpatient, Scottsbluff (Operational); Provider: Rg West Medical Center
- Crisis Response Team with ECS, Scottsbluff, Banner, Morrill Counties (Target Date 9/1/05) Provider: Region 1
- Crisis Respite, Scottsbluff (Operational); Provider: Region 1
- Dual Disorder Residential (2.5 beds), (Target Date 9/1/05); Provider Regional West Medical Center;
- Short Term Res. (1 bed) (Operational); Providers: NEPSAC, Humans Services Inc., Seekers of Serenity; 3 providers allows flexibility to serve persons quickly based on bed availability
- Medication Management, Regionwide (Operational); Provider Region 1

- Community Support, Chadron (Operational); Provider: Western Community Health Resources

**Region II - Reform Plan New Services (as of 8/5/05)**

- Crisis Respite, North Platte (Operational); Provider Liberty House
- Acute & Subacute Inpatient / North Platte, Kearney, (Operational); Providers Great Plains Medical Center and Richard Young
- Crisis Response Teams & Emergency Community Support North Platte (Operational); Provider Richard Young;
- Short Term Res. (3 beds) (Operational); Providers Touchstone, St. Monica's
- Dual Disorder Residential (2 beds) (Operational); Provider Centerpointe
- Community Support MH (40 slots), SA (20 slots), Region-wide (Operational); Providers Goodwill Industries and Region 2 Human Services
- Medication Management (60 clients), Region-wide (Operational); Provider Region 2
- Day Rehab, Region Wide (Operational); Provider Region 2 Human Services

**Region III Reform Plan New Services (as of 8/5/05)**

- Community Support SA(25 slots), (Operational); Provider: South Central BH Services
- Acute & Subacute Inpatient, Hastings, Kearney (Operational); Providers: Richard Young Hospital and Mary Lanning Hospital
- Short Term Res, 1 bed, Grand Island (Operational)
- Telemedicine (operational); providers MPC, Goodwill Greater NE, South Central Behavioral Services, Mary Lanning Memorial Hospital, Richard Young Hospital, Region 3 BH.
- Short Term Residential, (operational); Columbus
- Dual Disorder Residential (4 beds), (Target Date: 9/1/05); Catholic Charities, Columbus\*
- Crisis Response Team, (Operational); Grand Island, Kearney, Hastings, Custer County.
- Psych Res Rehab, 1 bed, Hasting (Operational); Provider: South Central Behavioral Services
- Community Support MH (60 slots) (Operational); Provider: Goodwill Industries Greater NE
- Medication Management (548 clients), (Operational); Provider Rich Young, Mary Lanning
- Crisis Stabilization Center, Grand Island; Provider: MP; Crisis Stabilization- Target Date 11/1/05; Psych Respite- Target Date 11/1/05; Medical Detox- Target Date 11/1/05; Urgent Outpatient- Operational; Emergency Community Support- Operational; Crisis Response- Operational; Crisis Med Mgmt. Operational; Drop In Center- Operational.
- Psych Respite, Kearney (Target Date: 9/1/05); Provider Richard Young
- Day Rehab, Kearney (Operational); Provider: South Central Behavioral Services
- Halfway House, Kearney (Operational); Provider: South Central Behavioral Health Services

\* **NOTE:** Dual Disorder Residential, Provider: Catholic Charities, 8 beds - Region 3 (4 beds) and Region 4 (4 beds) located in Central Nebraska

**Region IV Reform Plan New Services (as of 8/5/05)**

- Crisis Stabilization Center, (Target Date: 12/1/05); Provider: Catholic Charities, Columbus
- Psych Res Rehab (8 beds), (Target Date: 9/15/05); Provider: Catholic Charities, Columbus, In process of signing lease & remodeling
- Crisis Respite, (Operational); Provider: R Way, Liberty Center, Rainbow Center
- Crisis Response Team, (Operational); Provider: Norfolk
- Emergency Community Support (Operational); Provider: Heartland Counseling Services, Inc, So. Sioux City
- Community Support MH/SA, Region wide (Operational); Provider: Catholic Charities & Liberty Center (60 slots); SA Catholic Charities(25 slots)
- Medication Management- (Operational); Provider: Faith Regional (150 clients)
- Acute & Subacute Inpatient, (Target Date: 9/1/05); Provider: Faith Regional, Norfolk. Hospital attorneys reviewing contract language.
- Dual Disorder Residential (4 beds), (Target Date: 9/1/05); Catholic Charities, Columbus\*
- Day Rehabilitation Norfolk, Columbus and Wayne, (Operational); Providers: R way, Libery Centre, and Rainbow Center
- Psych Res Rehab, Columbus (Target Date: 9/01/05); Provider: Catholic Charities

**Region V Reform Plan New Services (as of 8/5/05)**

- ACT, Lincoln (Operational); Providers: The Community Mental Health Center (CMHC) of Lancaster County, Lutheran Family Services, and CenterPointe
- Community Support, MH (Operational); Provider: CMHC of Lancaster County
- Community Support, SA (25 slots) (Target Date: 9-1-05); Provider: Center Pointe
- Short Term Res.(4 beds) (Operational); Provider: Cornhusker Place, Touchstone
- Therapeutic Community,(2 beds) (Operational); Provider: St. Monica's
- Dual Residential, (2 beds) (Operational); Provider: Center Pointe
- Emergency Community Support (Operational); Providers: Blue Valley Mental Health Center, Lutheran Family Services, and Houses of Hope
- Crisis Response Teams, (Target Date:9/1/05); Providers: Blue Valley Mental Health Center, Lutheran Family Services, and Houses of Hope

**Region VI Reform Plan New Services (as of 8/5/05)**

- Crisis Response Teams, Cass, Dodge, Washington, Sarpy and Douglas Counties (Target Date: None); Provider: None.
- Emergency Community Support (Operational); Provider Salvation Army
- Phase I Psych Res Rehab, (12 beds) Omaha (Operational); Provider: Community Alliance
- Phase II Psych Res Rehab (8 beds) (Operational); Provider: Community Alliance
- ACT (#2), Omaha (Operational); Provider: Community Alliance
- Medication Management (3939 units),Omaha (Operational); Providers: Lutheran Family Services and Catholic Charities
- Day Rehab (47 slots), Omaha (Operational); Provider: Community Alliance
- Community Support MH (120 slots), (Operational); Providers - Catholic Charities, Friendship Program, and Lutheran Family Services

- Phase I Dual Disorder Res (8 beds), Omaha (Operational); Provider: Catholic Charities
- Phase II Dual Disorder Res (8 beds) Omaha, (Operational); Provider: Catholic Charities
- Subacute Inpatient, Omaha (Target date: 8/29/2005); Provider: telecare, Inc.)

Special note on Region 6 and the Community Resource Center (CRC)

- Region 6, the Division of Behavioral Health Services, community providers, and numerous leaders have been meeting to develop ideas relating to a Community Resource Center. The concept for the Community Resource Center is to provide a central location for psychiatric crisis and triage across a continuum of care that will ease the burden on strained emergency rooms and law enforcement in Region 6. The CRC would be open 24 hours per day, 7 days per week; able to serve individuals who are voluntary or involuntary, mentally ill, substance abuse and/or co-occurring, and are of age 19 and older. Appropriate movement between levels of care is designed to take place in a timely manner.
- The Community Resource Center may include some of the following services: Crisis Phone Line, Assessment, Minor Medical, EPC, Crisis Stabilization, Crisis Response Teams and Emergency Community Support. In addition, discussions have included how the universities might be able to use the center to provide education and research opportunities for mental health professionals and students in health care professions. It will also provide a base for consultations over a "telehealth" network expected to link sites across the state.

HOUSING-RELATED ASSISTANCE - As noted above, LB 40 (2005) amended Neb. Rev. Stat. § 71-812 (Behavioral Health Services Fund) to authorize the use of state funds to provide Housing-related assistance for very low-income adults with serious mental illness. All six Regions have signed contracts and are in the process of program development & implementation.

Regional Center Census –June 30, 2005 / Excludes: Adolescent, Forensic & Sex Offender Units

Regional Center	Unit	Census
Hastings Regional Center	Residential Rehab	38
Lincoln Regional Center	Short Term Care	40
	Community Transition	38
Norfolk Regional Center	Geriatric Medical – 1W	33
	SPMI, Male – 2E	37
	SPMI, Mixed – 3E	37
	Transition / Rehabilitation – 2W	36
	Admissions – 3W	36
<b>TOTALS Three Regional Centers as of June 30, 2005</b>		<b>295</b>

This table shows the census on the units in the three Regional Centers subject to the Behavioral Health Reform, as of June 30, 2005.

## **ADULT GOAL #2: EMPOWER CONSUMERS**

Each goal will address

- Areas Identified In the Previous State Plan As Needing Particular Attention
- The State's Priorities and Plans to Address Unmet Needs.

### **- Areas Identified In The Previous State Plan As Needing Particular Attention**

In the FY2005 application, this was presented as "ADULT GOAL #2 EMPOWER CONSUMERS".

### **- The State's Priorities and Plans To Address Unmet Needs.**

Office of Consumer Affairs.

§71-805 Neb. Rev. Stat. establishes an office of consumer affairs in the Division of Behavioral Health. A nationwide search was conducted in late 2004 and early 2005. A candidate was tentatively identified to be the Administrator of the office, but it did not work out. It is anticipated the new Administrator of the office of Consumer Affairs will be hired by the end of 2005 by the Director of Health and Human Services with consultation with the new Administrator of the Division of Behavioral Health.

### **Consumer Liaisons**

The Division of Behavioral Health Services has employed two consumers for over 13 years. Initially, these consumers were part time employees. In 1998, they were converted to full-time employees. The two full-time Consumer Liaisons on staff are Dan Powers and Phyllis McCaul. Overall, the consumer liaisons continue working as change agents and advocates as staff members within the Nebraska Department of Health and Human Services. Their leadership both within the Division of Behavioral Health Services and in community settings changes the dynamics of a meeting, with consumer concerns being addressed more consistently. Thus, in effect, this has operated as an Office of Consumer Affairs.

**FUNDING:** The Division of Behavioral Health Services allocates \$104,308 for State Administration (5%) from the Community Mental Health Services Block Grant (\$2,086,159 for FY2006) annually on consumer empowerment oriented activities. This includes funding two full-time Consumer Program Specialist (known as Consumer Liaisons) on staff as well as the Annual Consumer Conference (for about 100 mental health consumers). Annually the HHS funds a consumer conference designed to educate consumers in mental health issues and to speak up to national, state and local mental health officials to advocate on their and the systems behalf.

### **Funded Consumer Activities in FY 2006**

State Consumer Initiatives Contracts	
National Alliance for the Mentally Ill –Nebraska - The Office contracts with the National Alliance for the Mentally Ill -Nebraska to ensure a state organizational structure is available for consumers. It will also conduct consumer sensitivity training for administrative and front line staff of mental health and substance abuse providers.	\$46,445
League of Human Dignity - This contract is used to fund cash advances and reimbursements to consumers in order to help people attend meetings, workgroups	\$10,000

and conferences.	
Mental Health Association of Nebraska - The Office contracts with the Mental Health Association to ensure a state organizational structure is available for consumers and provide consumer sensitivity training to administrative and front line staff in Nebraska nursing homes and assisted living facilities	\$46,445
Partners in Recovery – for substance abuse consumers	\$43,245
Each region gets \$5,000 for Family Organizations – The Office partners with HHS Protection and Safety to fund family organizations to provide family mentoring services to families of SED Children. A Family Organization is funded in each region. The Office provides \$5,000 per Region. +	\$30,000
Peer Specialists - Goes to the Regions to pay for employees in Day Support who are peer specialists. These are Federal MH Services Block Grant aid funds in addition to the administrative set aside	\$60,000
Federal MH Services Block Grant 5% administrative set aside to fund two Consumer Liaisons & Annual Consumer Conference	\$104,308

WEB SITE: The Nebraska Department of Health and Human Services web site provides a summary on how to contact the Consumer Liaisons. Mental Health Consumer Advocacy  
<<http://www.hhs.state.ne.us/beh/mh/mhadvo.htm>>

#### AREAS OF WORK

This is a brief list of the areas the two Consumer Liaisons address:

- Mental Health Consumer Advocacy
- Annual Consumer Conference
- Advisors on HHS Community Mental Health Policy
- Promote the development of Peer Specialists
- State Advisory Committee on Mental Health Services Dan Powers is the Professional Staff to this committee from the Division
- Advisory Panel for the Health Systems Research Evaluation of the SAMSHA/CMHS Mental Health Block Grant Program." William Ford, Ph.D. a staff member of HSR is managing the first ever evaluation of the Mental Health Block Grant. Dr. Ford is a former Nebraskan and former Deputy Director of the Department of Public Institutions. Dan Powers is one of five members on the first evaluation of the Mental Health Block Grant. Mr. Powers is the Self-Identified Adult Mental Health Consumer on the Committee.
- Projects for Assistance in Transition from Homelessness (PATH) Dan Powers is the State PATH contact.
- National Association of Consumer/Survivor Mental Health Administrators. Dan Powers presented a resolution to the NAC/SMHA Board which supports the establishment of a national memorial for consumers who have been placed in unmarked or numbered graves. NAC/SMHA passed the resolution. Mr. Powers then presented the resolution to the National Association of State Mental Health Program Directors Board. The NASMHPD Board supported the resolution. Mr. Powers is the interim chair for the project. It is anticipated it will take 10 to 15 years to accomplish.

- National Mental Health Association Dan Powers is on the National Mental Health Association Nomination Committee and will be participating on two committees of the National Mental Health Association at Quarterly Meetings in Washington, DC area.
- Alegent Health . Dan Powers participated in the Alegent Health Decision Accelerator for planning for Mental Health and Substance Abuse Services .
- Co-Coordinate the annual Board of Mental Health Training
- Consumer Representative of Midwest Regional User Group sponsored by the Federal Center for Mental Health Services to address data infrastructure issues. Phyllis McCaul is the only consumer representative.
- Expansion of Site Visits (to 44 in a 24-month period) to review Substance Abuse Programs for Consumer Involvement and Outcomes. Phyllis McCaul conducts site reviews
- Continue Consumer Satisfaction Program Visits (totaling 52 in a 24-month period), including updated satisfaction survey. Phyllis McCaul conducts site reviews.
- Host 1-800 Phone Line and provide information regarding Mental Health and Substance Abuse Services.
- Consumer Mailing List developed and maintained
- Participate in SIG HHS Internal Stakeholders Committee meeting for Children's Mental Health Services. Phyllis McCaul is the only consumer representative on this committee.
- Child Services Initiative. Phyllis McCaul is consumer representative on this initiative.
- Mentor between 2 and 6 Nebraska Consumers at one or more National Mental Health Conferences each Year.

### **ADULT GOAL #3: SUICIDE PREVENTION INITIATIVE**

- Areas Identified In The Previous State Plan As Needing Particular Attention
- The State's Priorities And Plans To Address Unmet Needs.

#### **- Areas Identified In The Previous State Plan As Needing Particular Attention**

In the FY2005 application, this was presented as ADULT GOAL #3: SUICIDE PREVENTION INITIATIVE

- The State's Priorities And Plans To Address Unmet Needs.

The Nebraska Statewide Suicide Prevention Initiative Committee continues to meet regularly to update and revise goals and objectives for Nebraska's suicide prevention plan. No additional funding has been specifically budgeted or accessed for suicide prevention planning or support of state activities. The State Advisory Committee on Mental Health Services recommended, relative to the 2004 MH Block Grant Application, that the State seek federal funding. In response to this advice, Nebraska Health and Human Service System and the Nebraska State Suicide Prevention Committee submitted an application, on June 1, 2005, for State Sponsored Youth Suicide Prevention and Early Intervention Program. A response is anticipated in September of 2005.

The Southeast Nebraska Suicide Prevention Curricula continues to be disseminated. The core curriculum was presented by mental health consumers at the Nebraska Alliance for the Mentally Ill State Conference in 2004. It has been available for download through the University of

Nebraska Public Policy Center's faith initiative, NEHANDS, web site (<http://www.nehands.nebraska.edu/Resources.htm#Suicide>). It was also distributed to Nebraska faith based and community organizations via hard copy and cd-rom through Interchurch Ministries of Nebraska. Additionally, the curriculum was distributed to a national audience at the 2004 Christian Unity Conference in Omaha, Nebraska. The curriculum was sent to Dr. David Litts of the SPRC in 2004 for use as a model of public domain educational material that can be rapidly and widely disseminated and used by different groups. The clergy module of the Southeast Nebraska Suicide Prevention Curriculum contained eulogy recommendations that were piloted for the SPRC. The Law Enforcement Module has been fully integrated with the Nebraska Law Enforcement Training Academy and is now a standard part of the training that Law Enforcement recruits receive in the state of Nebraska. This year the Law Enforcement Module was presented to veteran officers in Northeast Nebraska as part of a NEHANDS funded collaborative project. The health care module has been translated into video format for easy viewing by health care personnel and is a standard part of the yearly training required by at least one of the major hospitals in Nebraska (BryanLGH Medical Center). It is also regularly presented to hospitals that are part of the Heartland Health Alliance across Nebraska.

The state committee participated in the development of Nebraska's injury prevention planning in the area of suicide prevention in 2005. The committee will have a regular presence in 2006 with the health department advisory group that includes planning for intentional self harm and youth prevention efforts.

On October 1, 2004, the Suicide Prevention Resource Center (SPRC) launched a new web service as part of its ongoing commitment to help states build capacity to implement and evaluate suicide prevention programs. This site links to the 2005 – 2006 Nebraska State Suicide Prevention Plan and a Nebraska suicide data fact sheet.

What's next? NE Health and Human Service System and the NE State Suicide Prevention Committee intends to promote mental health awareness, well-being, and the prevention of youth suicide by enhancing and expanding youth suicide prevention social awareness efforts; training and education; and coordination of care among health care providers and community organizations. Pending funding provided by the State-Sponsored Youth Suicide Prevention and Early Intervention grant, the Nebraska Youth Suicide Prevention Project goals are to:

1. Create an infrastructure and workplan for implementation of the Nebraska Youth Suicide Prevention Project.
2. Expand Project Relate, existing suicide prevention social marketing efforts in the state, to focus on youth suicide prevention.
3. Promote continued and expanded use of the Suicide Prevention Curriculum developed by the Nebraska State Suicide Prevention Committee.
4. Provide community-wide crisis management training and support for schools, law enforcement, faith-based communities, and other community and family support organizations dealing with a loss as a result of suicide.
5. Create a referral network of Primary Care Physicians and Mental Health Services Providers to immediately assist at risk youth and their families and to provide continuity of care.

6. Partner with juvenile correctional, detention, and out of home placement agencies across the region to adopt and utilize the Greenline Suicide Prevention Program to train facility staff on youth suicide prevention.
7. Partner with the School Community Intervention Program (SCIP) at the Lincoln Medical Education Partnership to increase the number of schools participating in the SCIP. Program and to increase the number of providers offering free SCIP Screenings to youth.
8. Enhance the ability of hotlines to appropriately assess and intervene with youth who are suicidal or depressed.

The proposed pilot project service area is Behavioral Health Region V, which encompasses a 16 rural and urban county area in southeast Nebraska. The total population of the Region V is 413,557 or 24 percent of the state's population. Almost 40 percent of the region's population resides in the service area's 15 rural counties.

Project outcomes will include increased social awareness on youth suicide intervention and prevention; consistency in community response to prevent and address youth suicides; improved communication between Primary Care Physicians and Mental Health Providers; improved treatment and continuity of care; a reduction in the number of youth suicides in Region V; and the expansion of the project into the State's other Behavioral Health Regions.

While the focus of the project is on youth, achievement of the project goals will simultaneously promote structures to prevent suicide in the adult population.

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## **ADULT'S PLAN**

Federal Requirements / PART C. State Plan

Section III. Performance Goals and Action Plans to Improve the Service System

### **Adult Criteria to be addressed in the State Plan**

#### **Criterion 1: Comprehensive Community-Based Mental Health Service Systems**

- Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness.
- Describes available services and resources in a comprehensive system of care, including services for individuals with both mental illness and substance abuse. The description of the services in the comprehensive system of care to be provided with Federal, State, and other public and private resources to enable such individuals to function outside of inpatient or residential institutions to the maximum extent of their capabilities shall include:
  - Health, mental health, and rehabilitation services; • Employment services; • Housing services;
  - Educational services; • Substance abuse services; • Medical and dental services;
  - Support services; • Services provided by local school systems under the Individuals with Disabilities Education Act; • Case management services; • Services for persons with co-occurring (substance abuse/mental health) disorders; and • Other activities leading to reduction of hospitalization.

**(i) Current Activities**

**Organizational Structure for the System of Care:**

Nebraska Behavioral Health Services Act, Neb. Rev. Stat. §§ 71-801 to 71-820 (Laws 2004, LB 1083, §§ 1 – 20) establishes the framework for the provision of behavioral health services.

- Under § 71-803 the purposes of the Public Behavioral Health System are to ensure:
  - (1) The public safety and the health and safety of persons with Behavioral Health disorders;
  - (2) Statewide access to Behavioral Health services
  - (3) High quality Behavioral Health services
  - (4) Cost-effective Behavioral Health services
- Under § 71-804 (2) **Behavioral health disorder means mental illness or alcoholism, drug abuse, problem gambling, or other addictive disorder;**
- 71-804 (4) Behavioral health services means services, including, but not limited to, consumer-provided services, support services, inpatient and outpatient services, and residential and nonresidential services, provided for the prevention, diagnosis, and treatment of behavioral health disorders and the rehabilitation and recovery of persons with such disorders;
- Under §§ 71-807 to 71-809, the six Regional Behavioral Health Authorities (RBHA) are established.
- 71-806 (1) says the Division shall act as the chief Behavioral Health authority for the State of Nebraska. HHS contracts with the six Regional Behavioral Health Authorities established under §§71-807 to 71-809 to purchase community mental health services. State and federal community mental health funds are allocated to the RBHAs by contract for service delivery at the local level. The RBHAs contract with public and/or private service agencies or individuals to provide services in their regions or assume direct responsibility for the provision of community-based services. A further description of the State's community-based system of care is provided in Section II of this application.

In general, for a consumer to access any of the behavioral health services presented in this section and are funded in whole or in part by the Nebraska Division of Behavioral Health Services, he/she needs to contact the Regional Behavioral Health Authority in the area.

- Region 1 Behavioral Health Authority - 4110 Avenue D; Scottsbluff, NE 69361 (308-635-3171)
- Region 2 Behavioral Health Authority - 110 North Bailey Street; P.O. Box 1208; North Platte, NE 69103; (308-534-0440)
- Region 3 Behavioral Health Authority; 4009 6th Avenue, Suite 65; P.O. Box 2555; Kearney, NE 68848; (308-237-5113)
- Region 4 Behavioral Health Authority; 206 Monroe Avenue; Norfolk, NE 68701; (402-370-3100)
- Region 5 Behavioral Health Authority; 1645 "N" Street Suite A; Lincoln, NE 68508 (402-471-6400)
- Region 6 Behavioral Health Authority; 3801 Harney Street; Omaha, NE 68131-3811; (402-444-6573)

Here is a description of services that support adults with SMI in the community in the areas of health, mental health, rehabilitation services, employment services, housing services, educational services, substance abuse services, medical services, dental services, support services, case

management services, services for persons with co-occurring (substance abuse/mental health) disorders, other activities leading to reduction of hospitalization.

The Division of Behavioral Health Services has the responsibility to ensure that the community mental health, substance abuse, and gambling assistance services needed by Nebraskans are available and accessible in Nebraska. Here is an overview:

- The General Mental Health Services array includes specialized mental health treatment services that have a primary acute care mission. The main focus of these services is appropriate diagnosis and the amelioration of symptoms through effective treatment. For the most part, mental health services delivered through these service options are short-term and time-limited.
- The Psychiatric Rehabilitation and Support array is composed of specialized mental health services that have a primary psychiatric rehabilitation and support mission. Here the main focus shifts from illness to disability with the goal of providing the support necessary for the individual to live in the least restrictive setting. These services also focus on rehabilitative interventions that allow the consumer to overcome or maximally compensate for the deficits produced by mental illness. The Psychiatric Rehabilitation and Support Array, in contrast to the General Mental Health Services array, is composed of long-term services that assume the need for consistent (at least once per week) involvement with one or more of the Rehabilitation and Support services over a long period of time (months or years).

**Case Management System** - In Nebraska, case management services are part of the service referred to as "Community Support". From a consumer's point of view being found eligible for Community Support Services is required. A description of the Community Support Mental Health-Adult is

1. For persons disabled by severe and persistent mental illness.
2. Staff provide direct face to face contact with the consumer to develop skills necessary to live as independent a life in the community as the consumer is able.
3. Emphasis is on an active rehabilitation plan addressing all functional deficits.
4. Ancillary services include **case management** and advocacy.

Please note item 4 includes **case management**. Items 1-3 go far beyond that.

In order to enable individuals with Serious Mental Illness (SMI) to function outside of inpatient or residential institutions to the maximum extent of their capabilities, the "Community Support" service is used. There is Emergency Community Support, Community Support Mental Health and Community Support Substance Abuse. These services provide linkages, referrals and coordination of necessary services and supports as identified in the Individual Service Plan (ISP) to ensure consumer recovery, including, but not limited to: **health, mental health, rehabilitation services; employment services; housing services; educational services; substance abuse services; medical and dental services; support services; case management services; and other activities to help reduce psychiatric hospitalization.**

The role(s) of the community support provider may vary based on consumer's needs. This is because community support is an in-vivo service with most contacts typically occurring outside the program office. Most services are provided in the consumer's place of residence or other

community locations consistent with consumer's choice or need. The contact frequency is individualized and adjusted in accordance with the level of rehabilitation and support needed.

The intent of the service is to increase independent living skills, enhance quality of life, and decrease the frequency and duration of hospitalization by linking the consumer to appropriate service providers, providing rehabilitative/support services and monitoring service provision of other allied service providers. Community Support occurs on an ongoing basis at the individual's place of residence or other locations as specified in the consumers Individual Service Plan (ISP). The community support program provides a clear focus of accountability for meeting the consumer's needs within the resources available in the community.

**Employment services** – The Nebraska Division of Behavioral Health Services has a long established working relationship with the Nebraska Vocational Rehabilitation Services (VR). This has lead to the development of employment services in the Regions via cooperative agreements between State VR and local providers. As noted in SECTION III. A. Fiscal Planning Assumptions, in FY2006, \$460,567 of State funds are being used to help pay for these vocational services. In FY2006, the goal is to have these employment agreements in all six Regional Behavioral Health Authorities.

**Housing services** – Nebraska has facility based housing programs (Psychiatric Residential Rehabilitation and Dual Residential). In addition, under Neb. Rev. Stat. § 71-812 (LB 40/2005) authorizes the use of state funds to provide Housing-related assistance for very low-income adults with serious mental illness. Housing-Related Assistance includes rental payments, utility payments, security and utility deposits, and other related costs and payments.

**Substance abuse services** – It is important to remember that Nebraska statute [§ 71-804 (2)] defines “Behavioral health disorder” as mental illness or alcoholism, drug abuse, problem gambling, or other addictive disorder. The Nebraska Legislature expects the Division of Behavioral Health Services to fully address this issue. Division of Behavioral Health Services and Medicaid adopted “American Society of Addiction Medicine” (ASAM) Standards for use in the implementation of the 1915B Waiver for Adult Substance Abuse services. This expectation is accomplished as demonstrated by the data reported under Criterion 2 in the table on Magellan Behavioral Health, Unduplicated Persons Served for FY2005. The table shows persons served by type of service: Mental Health only = 17,912 (54.28%); Substance Abuse only = 14,853 (45.01%); and Dual only = 503 (1.52%).

One expectation of Behavioral Health providers in Nebraska is that they should have arrangements to assess the need for mental health and substance abuse services among clients of the agency. Upon recognition, the provider makes suitable arrangements available to the client either through referral or as a part of the program activities. An ongoing requirement in service definitions since 1998 includes all of primary mental health treatment services screen for substance abuse and seek consultation for further evaluation. All of the primary substance abuse treatment services screen for mental illness and seek consultation for further evaluation.

**Services for persons with co-occurring (substance abuse/mental health) disorders**

Official state definitions on services for individuals diagnosed with both mental illness and substance abuse include:

- (a) Dual Disorder: an adult with a primary severe and persistent mental illness AND a primary chemical dependency disorder. An adolescent with a primary severe emotional disturbance and a primary chemical dependency (or diagnosed entrenched dependency pattern).
- (b) Dual Disorder Treatment: dual disorder services provide primary integrated treatment simultaneously to persons with an Axis I chemical dependency AND an Axis I major mental illness. Clients serviced exhibit more unstable or disabling co-occurring substance dependence and serious and persistent mental illness disorders. The typical client is unstable or disabled to such a degree that specific psychiatric and mental health support, monitoring and accommodation are necessary in order to participate in addictions treatment. Providers of Dual disorder treatment programs demonstrate a philosophy of integrate treatment in treatment plans, program plans, staffing, and services provided. Both disorders are treated as equally primary. Appropriate licensed and certified staff including staff with addiction certification is required to provide treatment.
- (c) Dual Enhanced Treatment: a service for persons whose mental illness or substance disorder is less active than the primary diagnosis. Providers of these treatment services may elect to enhance their primary service to address the client's other relative stable diagnostic or sub-diagnostic co-occurring disorder. The primary focus of such programs is mental health or addictions treatment rather than dual diagnosis concerns and is not a primary, integrated dual disorder treatment.

DUAL DISORDER RESIDENTIAL is a facility based service licensed as a mental health center, residential care facility, or substance abuse treatment facility. It is defined as a program for persons disabled by SPMI and substance dependence (primary Axis I diagnoses in of major mental illness and substance dependence) who are unable to reside in less restrictive setting due to pervasiveness of impairment. The program has the capacity to take committed clients. The services include a Comprehensive MH and SA evaluation prior to admission completed by LMHC and LADAC or dually credentialed professional; Active and integrated treatment and rehabilitation plan, reviewed at least every 3 months; Relapse prevention planning; Discharge planning begins at admission; Medication management; Psycho-educational services; Educational, vocational, social skill building, recreational, spiritual, ADLs, community supports; and Individual/group/family therapy. The average Length of Stay (LOS) is six months.

Current capacity for Dual Disorder Residential Based on FY2004 actuals:

- From Region 4 Behavioral Health Authority shows one provider of Dual Residential services. W.E.L.L. Link, Inc. reported Beds 8 and 25 Persons Served.
- From Region 5 Behavioral Health Authority reported Dual Residential provider CenterPointe had 8 beds and served 32 in FY2004.

As noted under Adult Goal #1: Behavioral Health Implementation Plan, each Region has plans to expand Dual Disorder Residential Services.

- Region 1 - (2.5 beds), (Target Date 9/1/05); Provider Rg West Medical Center, Scottsbluff.

- Region 2 - (2 beds), (Operational); Provider Centerpointe, Lincoln
- Region 3 - (4 beds), (Target Date 9/1/05) provider: Catholic Charities, Columbus
- Region 4 - (4 beds), (Target Date 9/1/05) provider: Catholic Charities, Columbus
- Region 5 - (2 beds), (Operational); Provider: Center Pointe, Lincoln
- Region 6 - (16 beds), (Operational); Provider: Catholic Charities, Omaha

**Mental Health and Rehabilitation Services** – here is a listing of the types of mental health and rehabilitation services purchased by the Division of Behavioral Health Services from the six Regional Behavioral Health Authorities.

### **MENTAL HEALTH EMERGENCY**

24-Hour Crisis Line – Telephone access 24-hours/day, 7 days a week to staff trained in Mental Health support with access to Mental Health Professionals.

Mobile Crisis – A two-person team offers on-site services assessment and crisis stabilization for individuals experiencing a mental health crisis; includes access to trained mental health staff, 24-hours/7days per week to provide interventions and/or screenings.

Crisis Respite – 24-hour short-term residential care typically for no more than 3 days for individuals with a severe and persistent mental illness needing supervised assistance to stabilize on their medications or get back on their medications.

Emergency Community Support – Aftercare service for individuals who have received Emergency Services; includes service identification, ensure arrangement and attendance at services, coordination of a care plan, provide or arrange for transportation, assist with housing, and direct support for teaching activities of daily living to keep someone out of the hospital. This service may begin until longer-term community support is available in the home community. The emergency community support averages no more than 120 days.

Crisis MH Assessment (see Crisis Center) – A thorough mental health assessment/evaluation completed by a psychiatrist for persons admitted to a Crisis Center on an EPC involuntary hold to determine mental illness diagnosis, dangerousness, and recommended service level. An evaluation for the Emergency Protective Custody (EPC) hold is completed within 36 hours to determine if further action should be taken.

Crisis Center (EPC) – 24-hour medical facility that can provide emergency care to stabilize a person on an EPC hold who is alleged to be mentally ill and dangerousness and/or chemically dependent and dangerousness.. The county attorney makes a decision within 72 hours whether to request a hearing to involuntarily require someone to receive appropriate mental health and/or substance abuse services. An EPC hold can be dropped after the evaluation if no mental illness or chemical dependency is found, or if the person agrees to voluntarily seek treatment. A commitment hearing must be held within 7 days of admission.

### **MENTAL HEALTH RESIDENTIAL**

Psychiatric Residential Rehabilitation (Psych Res Rehab) – 24 hour, residential facility in the community for persons with severe and persistent mental illness. Persons in this service need the 24-hour structured psychosocial rehabilitation and medication management to regain or relearn skills that will allow them to live independently in their communities. Length of

service varies depending on individual needs but is not longer than 4-8 months. Length of service varies depending on individual needs but is usually not longer than 9-18 months.

Dual Residential -- Facility based program that provides simultaneous integrated treatment for individuals with severe and persistent mental illness and chemical dependence. Includes medication management and psychosocial rehab as well as treatment for stabilization and recovery. Substance abuse and mental health professionals staff the service. Substance abuse and mental health treatment are integrated. Length of service varies depending on individual needs but is not longer than 4-8 months.

### **MENTAL HEALTH NON-RESIDENTIAL**

Assertive Community Treatment – Self-contained ten-member clinical team which assumes responsibility for directly providing comprehensive treatment, rehabilitation and support services to eligible consumers with severe and persistent mental illness. Often termed a “hospital without walls”, it allows for a team of professionals to be responsible for whatever it takes to keep someone out of the hospital. A team leader, psychiatrist, nurses, licensed mental health practitioner, certified substance abuse counselor, vocational specialist, peer specialist and other mental health professionals are full time members of the team. Because of the lack of psychiatrists and other clinically trained professionals on the team, this team approach to service provision has limited applicability in rural areas. Duration of this service is as needed to achieve stability in the functional deficit areas.

Day Treatment – Specialized medically based day program for persons with serious mental illness that enables a person to live independently and still attends an intensive program including assessment, individual, family and group therapy, and medication services as developed by a multidisciplinary team. Programming usually involves 6-8 hours of activity per day/6-7 days per week. Length of service varies depending on individual needs but is usually not longer than 21-45 days.

Day Rehabilitation – Facility based day program for a person with severe and persistent mental illness that focuses on psychosocial rehabilitation after treatment has stabilized the mental illness. Provides prevocational and transitional employment services, planned socialization, skill training in activities of daily living, medication management, and recreation activities are focused on returning a person to work and maintaining independence in the community. Programming usually involves 5 hours of activity per day/5 days per week and some weekends. Length of service varies depending on individual needs but is usually not longer than 6 months – 5 years.

Vocational Rehabilitation – Job coaching and supported employment funded through the Division of Vocational Rehabilitation with matching funds from the NBHS system. Services are provided to persons with severe and persistent mental illness.

Community Support – With 24 hour, 7-day/week availability, provides consumer advocacy, ensures continuity of care, active support in time of crisis, provides direct skill training in the residence and community, provide or arrange for transportation, arrange for housing, acquisition of resources and assistance in community integration for individuals with severe and persistent mental illness. Length of service varies depending on individual needs but is usually not longer than 6 months – 2 years.

Outpatient/Assessment – Assessment, diagnosis and psychotherapy/counseling for a variety of mental health problems which disrupt individual's life that includes counseling and talk therapy treatment to change behavior, modify thought patterns, cope with problems, improve functioning; may include coordination to other services to achieve successful outcomes. Length of service varies depends on individual illness and response to treatment but averages 10 sessions at least once per week. Group therapy sessions include approximately 3-8 persons. Family counseling are included in this service level.

Psychological Testing – Psychological and diagnostic tests completed by a licensed, clinical psychologist.

Medication Management – Prescription of appropriate psychotropic medication (usually, but not limited to persons with severe and persistent mental illness), and follow-up to therapeutic response, including identification of side effects. Medication checks usually take 15-30 minutes with the psychiatrist, an/or a nurse or case manager.

Vocational Support – Ongoing support for persons with severe and persistent mental illness after they have secured long term employment. The support activities general take place off the job site, but can include assistance in learning job duties, problem solving and other job functions in order for individual to maintain gainful employment. Length of service depends on individual consumer need but is usually not longer than 6-24 months.

Day Support (Drop-In Center w/Peer Support) -- Facility based program for persons with severe and persistent mental illness. This transition "drop-in" center for persons who have not yet enrolled in Day Rehabilitation, or who have completed their rehab plan in the Day Rehab service and want to continue to socialize with friends they have made at the Day Rehab service is designed to engage consumers. This service does not require a service plan but provides an environment to be with other people who share the same life and illness situation. Persons with severe and persistent mental illness are hired as peer specialist staff in this program. Additional support including outreach are the main focus of this drop in center. Pre-Day Rehab consumer length of stay may be 3-6 months. Post-Day Rehab consumer length of service is very individualized and may range from 6 months – 5+ years.

Care Monitoring (MH) -- Ongoing support case management service for persons who no longer need the active rehabilitation service of Community Support. Length of service depends on individual consumer need with documented client contact of no more than one time per month in person or by phone.

### **Regional Center Capacity as of July 26, 2005**

The state has three regional centers (state hospitals for the mentally ill), located in Hastings, Lincoln, and Norfolk, which are operated by the Department of Health and Human Services.

#### **Lincoln Regional Center, Lincoln NE (LRC)**

<b>LRC Programs</b>	<b>Capacity</b>
Short Term Care (STC)	43
Community Transition Program (CTP)	40
Forensic Psychiatric Program (PSYC)	43
Forensic Sex Offender Program (SOS)	64
Forensic Sex Offender Transition Program-Males (FMHS-SOST)	16

Forensic Sex Offender Transition Program-Females (FMHS-SOSF)	5
Adolescent Inpatient-Acute (PSYA)	5
Adolescent Residential Treatment Care (PSYR)	16
Adolescent Sex Offender Residential Treatment (Whitehall)-Male Only	16
Adolescent Sex Offender Treatment Group Home (Whitehall)-Male Only	8

**Norfolk Regional Center, Norfolk, NE (NRC)**

<b>Programs</b>	<b>Capacity</b>
1 West: SPMI w/ medical comp	33
2 West: Transition/ Rehab	36
3 West: Admissions	36
2 East: SPMI, Male	37
3 East: SPMI, Mixed	37

**Hastings Regional Center, Hastings, NE (HRC)**

<b>Programs</b>	<b>Capacity</b>
Unit 37 – Residential	30 Males 10 Females
Unit 81 – Adolescent Chemical Dependency	40 Males

**(ii) Goals, Targets and Action Plans**

Criterion 1: Comprehensive Community- based Mental Health Service Systems

GOAL: Maintain capacity of Community Support Services (2004)

**FY 2005 Nebraska MENTAL HEALTH PLAN**

**Criterion 1: Comprehensive Community- based Mental Health Service Systems**

**GOAL:** Increase the capacity of Community Support Services

**OBJECTIVE:** In light of Behavioral Health Reform, by June 30, 2006, the number of persons served with Serious Mental Illness receiving Mental Health Community Support Services will be increased by 10%.

**POPULATION: SMI Adults**

Performance Indicator	FY2003 Actual	FY2004 Actual	FY2005 Target	FY2005 % Attained	FY2006 Target
Value:	2,644	2,832	3,000		3,300

Number of persons SMI who are receiving Mental Health Community Support (including case management) services

Value = all persons reported SMI receiving Mental Health Community Support

Data source: from Nebraska Division of Behavioral Health Services

Community Support - Mental Health  
Medicaid Rehabilitation Option (MRO ELIGIBLE and NON-MRO ELIGIBLE)

	FY03 # Persons Served	% of Total	FY04 # Persons Served	% of Total	Population (2000)	
					#	% of state population
Region 1 totals	166	6.3%	141	4.98%	90,410	5.3%
Region 2 totals	239	9.0%	242	8.55%	102,311	6.0%
Region 3 totals	289	10.9%	363	12.82%	223,143	13.0%
Region 4 total	277	10.5%	293	10.35%	216,338	12.6%
Region 5 totals	1185	44.8%	1345	47.49%	413,557	24.2%
Region 6 Totals	488	18.5%	448	15.82%	665,454	38.9%
Totals Regions 1-6	2644	100.0%	2832	100.00%	1,711,213	100.0%

Source: as reported by the Six Regional Behavioral Health Authorities, September 2004

**Criterion 2: Mental Health System Data Epidemiology**

- Contains an estimate of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children; and
- Presents quantitative targets to be achieved in the implementation of the system of care described under Criterion 1.

**(i) Current Activities**

The Nebraska Databook reports the state's population in 2003 is 1,739,291.  
(see <<http://info.neded.org/databook.php>>).

**Nebraska Statewide by Race (2000 Census)**

Total	White	Black	American Indian, Eskimo or Aleut	Asian or Pacific Islander	Hispanic Origin <sup>1</sup>	Other Races <sup>2</sup>
1,711,263	1,533,261	68,541	14,896	22,767	94,425	71,798
100.0%	89.6%	4.0%	0.9%	1.3%	5.5%	4.2%

**Nebraska Statewide by Sex**

Male	843,351	49%
Female	867,912	51%
TOTAL	1,711,263	100%

Source: Last Updated: 2/26/02 By Nebraska Databook -  
<http://info.neded.org/stathand/bsect8.htm>  
Based on data from U. S. Bureau of the Census Web site ([www.census.gov](http://www.census.gov)) 2001.

**Metropolitan Statistical Areas (MSA) 50,000 or more**

In Nebraska there are six counties designated as “Metropolitan Statistical Areas” by the U.S. Census Bureau. These counties are

Region VI – Douglas (includes City of Omaha / 390,007), Sarpy, Cass, Washington,

Region V – Lancaster (includes City of Lincoln / 225,581),

Region IV – Dakota county (includes South Sioux City / 11,925) connected to Sioux City, Iowa.

SARPY County includes Offutt Air Force Base in the Omaha, NE—IA MSA.

More than half of Nebraska’s population now lives in metropolitan areas. As of 2000, the Nebraska portion of the “Omaha, NE—IA MSA” (Cass, Douglas, Sarpy, and Washington Counties) is 629,294 people. The “Lincoln, NE MSA” (Lancaster County) has 250,291. These two MSAs have 879,585 people accounting for 51.4% of the state population.

The Nebraska portion of the “Sioux City, IA—NE MSA” (Dakota County, NE) has 20,253 people. When combined with the other two MSAs in Nebraska, there is a total of 899,838 people accounting for 52.6% of the 1,711,263.

**Micropolitan Statistical Areas 10,000 to 49,999**

The COUNTY is in CAPS; the Core Based Statistical Area Population of 10,000 to 49,999 is noted as the “city” within the county listed.

- Region I has SCOTTS BLUFF (36,951) with the Scottsbluff / Gering Area (23,129) consisting of the cities of Scottsbluff (14,732), Gering (7,751), and Terrytown (646).
- Region II has LINCOLN (34,632) with the City of North Platte (23,878) and DAWSON (24,365) with the City of Lexington (10,011)
- Region III has HALL (53,534) with the City of Grand Island (42,940); BUFFALO (42,259) with the City of Kearney (27,431); and ADAMS (31,151) with the City of Hastings (24,064).
- Region IV has MADISON (35,226) with the City of Norfolk (23,516); PLATTE (31,662) with the City of Columbus (20,971);
- Region V has GAGE (22,993) with the City of Beatrice (12,496)
- Region VI has DODGE (36,160) with the City of Fremont (25,174)

**Rural and Frontier areas**

On the other end of things is the Frontier area concept. According to Rural Policy Research Institute (University of Missouri, Columbia, MO) the term “Frontier Area” is used to describe an area with extremely low population density. Frontier Areas are isolated rural areas characterized by considerable distances from central places, poor access to market areas, and people’s relative isolation from each other in large geographic areas.

The National Rural Institute on Alcohol and Drug Abuse uses the following definitions:

- Rural areas contain 50 or fewer people per square mile
- Frontier areas contain 6 or fewer people per square mile.

Overall, Nebraska has 22.3 Persons Per Square Mile.

Applying these standards to Nebraska's "Population Density By County" shows:

- 52 – Rural counties (604,757 population; 35% total population / areas containing 50 or fewer people per square mile)
- 33 – Frontier Counties (93,711 population; 5% total population / areas contain 6 or fewer people per square mile).
- 8 – remaining Nebraska Counties (1,012,795 population, 59% total population / with more than 50 people per square mile. The Nebraska Counties with more than 50 people per square mile were Adams, Hall (Region 3), Madison, Dakota (Region 4), Lancaster (Region 5) and Dodge, Sarpy, Douglas (Region 6).

Source: Fact Sheet #1 "Definitions of Rural"

National Rural Institute on Alcohol and Drug Abuse; University of Wisconsin-Stout;  
140 Vocational Rehabilitation Building; P.O. Box 0790; Menomonie, WI 54751-0790

Nebraska has **33 Frontier Area counties**. This includes 11 counties with less than 1,000 people [Keya Paha (983), Wheeler (886), Banner (819), Hooker (783), Logan (774), Grant (747), Thomas (729), Loup (712), Blaine (583), McPherson (533), And Arthur (444)].

#### Estimate of the Incidence and Prevalence in the State of Serious Mental Illness Among Adults

Prevalence estimates for SMI and SED.

Adults with Serious Mental Illness (SMI)	70,480
Children with Serious Emotional Disturbances (SED)	22,146

source: State Data Infrastructure Coordinating Center, National Association of State Mental Health Program Directors Research Institute, Inc. (NRI) under contract with the Federal Center for Mental Health Services (CMHS) (contract no. 280-99-0504) August 2005.

<http://www.nri-inc.org/SDICC/SDICC05/05files.cfm>

U.S. Department of Health & Human Services, Center for Mental Health Services (CMHS)

#### Profile of Persons with SMI/SED served by Age

Age / SED	Total	Age / SMI	Total	Age	Total
0-3 Years	84	18-20 years	231	Not Available	2
4-12 years	37	21-64 years	6,336		
13-17 years	152	65-74 years	176		
		75+ years	71		
SED Total	273	SMI Total	6,814	Total	7,089
Under 18 years	450,242	18 years & older	1,261,021	Total NE Population	1,711,263

Source:

- Table 14A. Profile of Persons with SMI/SED served by Age, Gender and Race/Ethnicity; Nebraska Community Mental Health Services Block Grant FY2004 / Implementation Report
- Nebraska 2000 State Census Profile <<http://info.neded.org/neprof00.htm>>

**Federal Serious Mental Illness (SMI) Criteria** - Pursuant to section 1912(c) of the Public Health Service Act, adults with serious mental illness SMI are persons: (1) age 18 and over and (2) who currently have, or at any time during the past year had a diagnosable mental behavioral or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-IV or their ICD-9-CM equivalent (and subsequent revisions) with the exception of DSM-IV "V" codes, substance use disorders, and developmental disorders, which are excluded, unless they co-occur with another diagnosable serious mental illness. (3) That has resulted in functional impairment, which substantially interferes with or limits one or more major life activities. Federal Register Volume 58 No. 96 published Thursday May 20, 1993 pages 29422 through 29425.

For the purposes of the Nebraska Mental Health Block Grant reporting the number of persons served who meet this SMI criteria, the following methods were used to operationalize this definition:

- Step 1: a diagnosable mental, behavioral, or emotional disorder - Diagnosis # 295 - 298.9 [Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR) © 2000 American Psychiatric Association. Schizophrenia (295), Mood Disorders including Bipolar and Major Depression (296), Delusional Disorder (297.1), Shared Psychotic Disorder (297.3), Brief Psychotic Disorder (298.8), and Psychotic Disorder NOS (298.9) ["Not Otherwise Specified"]. ... and ...
- Step 2: resulted in functional impairment – The functional impairment component of the SMI designation is addressed by:
  - a. SSI/SSDI eligible (include eligible receiving pay, eligible not receiving pay, potential eligible) or
  - b. Served in one of the NBHS funded Community Mental Health Rehabilitation Based Services (Community Support, Assertive Community Treatment, Psychiatric Residential Rehabilitation, Day Treatment, Day Rehabilitation, Day Support, Vocational Support, or related psychiatric rehabilitation services) or
  - c. Have an Axis V – Global Assessment of Functioning (GAF) Scale score of less than 60.

**STATE REGIONAL CENTER DATA (State Psychiatric Hospitals)**  
**Lincoln Regional Center, Norfolk Regional Center, Hastings Regional Center**  
**Adults, Age 18 or older, Inpatient (Actual)**

Regional Center Data - Age 18+      FY2002 - FY2005

Number of **Admissions** to a State Regional Center

<b>FY2002</b>	<b>FY2003</b>	<b>FY2004</b>	<b>FY2005</b>	
1,097	1,115	1,148	988	Number of admissions
693	667	730	667	Number of admissions with SMI
430	551	619	436	Number of admissions with a substance abuse diagnosis

Number of **Discharges** from a State Regional Center

<b>FY2002</b>	<b>FY2003</b>	<b>FY2004</b>	<b>FY2005</b>	
614	660	722	671	Total discharges with SMI
1,087	1,165	1,146	1,009	Total discharges

Average/median length of stay (in days) for persons with SMI discharged from a State Regional Center

FY2002	FY2003	FY2004	FY2005	
185.9	159.0	166.3	138.5	Average length of stay in days
66.0	62.0	59.0	60.5	Median length of stay in days

\*\* Does not include transfers between regional centers or persons discharged for short-term treatment in a general hospital who are expected to return.

Prepared by Paula Hartig, July 20, 2005; Research and Performance Measurement; Financial Services Division; HHSS – Finance & Support

**Regional Center Unduplicated Persons Served  
Inpatient and Residential Services  
FY2002 - FY2005 Age 0-17**

	FY2002		FY2003		FY2004		FY2005	
	N	%	N	%	N	%	N	%
<b>TOTAL YOUTH SERVED</b>	118	---	112	---	216	---	180	---
<b>Age:</b>								
10-14 years	15	12.7%	24	21.4%	27	12.5%	19	10.6%
15-17 years	103	87.3%	88	78.6%	189	87.5%	161	89.4%
<b>Gender:</b>								
Male	93	78.8%	89	79.5%	181	83.8%	148	82.2%
Female	25	21.2%	23	20.5%	35	16.2%	32	17.8%
<b>Employment Status:</b>								
Student	109	92.4%	109	97.3%	213	98.6%	177	98.3%
Unemployed	8	6.8%	2	1.8%	3	1.4%	3	1.7%
Employed - Full-Time	1	0.8%	1	0.9%	0	0.0%	0	0.0%
<b>Race:</b>								
White	88	74.6%	87	77.7%	151	69.9%	122	67.8%
Black/African American	13	11.0%	11	9.8%	32	14.8%	25	13.9%
American Indian	6	5.1%	6	5.4%	16	7.4%	12	6.7%
Asian/Pacific Islander	1	0.8%	0	0.0%	1	0.5%	1	0.6%
Bi-Racial	4	3.4%	5	4.5%	14	6.5%	14	7.8%
Other	0	0.0%	2	1.8%	1	0.5%	1	0.6%
Not Reported	6	5.1%	1	0.9%	1	0.5%	5	2.8%
<b>Hispanic Origin:</b>								
Yes	12	10.2%	11	9.8%	21	9.7%	17	9.4%
No	106	89.8%	101	90.2%	195	90.3%	163	90.6%
<b>Legal Status at Admission:</b>								
Voluntary	11	9.3%	14	12.5%	83	38.4%	72	40.0%
Court Order	84	71.2%	71	63.4%	117	54.2%	101	56.1%
EPC	15	12.7%	22	19.6%	15	6.9%	7	3.9%
Other	8	6.8%	5	4.5%	1	0.5%	0	0.0%

<b>Diagnosis:</b>								
Conduct Disorder	2	1.7%	3	2.7%	6	2.8%	9	5.0%
Substance Abuse/Dep	53	44.9%	56	50.0%	95	44.0%	77	42.8%
Alcohol Abuse/Dependence	16	13.6%	6	5.4%	13	6.0%	13	7.2%
Major Depressive Disorder	2	1.7%	4	3.6%	8	3.7%	5	2.7%
Bipolar Disorder	7	5.9%	5	4.5%	10	4.6%	20	11.1%
Anxiety Disorder	0	0.0%	4	3.6%	0	0.0%	1	0.6%
Other	38	32.2%	34	30.4%	84	38.9%	55	30.6%

Prepared by Paula Hartig, July 20, 2005; Research and Performance Measurement; Financial Services Division; HHSS – Finance & Support

**Regional Center Unduplicated Persons Served  
Inpatient Services FY2002 - FY2005 Age 18+**

	FY2002		FY2003		FY2004		FY2005	
	N	%	N	%	N	%	N	%
<b>TOTAL ADULTS SERVED</b>	1,375	---	1,353	---	1,223	---	1,110	---
<b>Age:</b>								
18-19 years	62	4.5%	65	4.8%	55	4.5%	43	3.9%
20-24 years	164	11.9%	172	12.7%	159	13.0%	162	14.6%
25-34 years	305	22.2%	342	25.3%	313	25.6%	258	23.2%
35-44 years	411	29.9%	371	27.4%	342	28.0%	310	27.9%
45-54 years	275	20.0%	267	19.7%	224	18.3%	201	18.6%
55-64 years	111	8.1%	96	7.1%	97	7.9%	103	9.3%
65-74 years	32	2.3%	27	2.0%	28	2.3%	23	2.1%
75+ years	15	1.1%	13	1.0%	5	0.4%	4	0.4%
<b>Gender:</b>								
Male	950	69.1%	897	66.3%	848	69.3%	746	67.2%
Female	425	30.9%	456	33.7%	375	30.7%	364	32.8%
<b>Employment Status:</b>								
Student	24	1.7%	39	2.9%	22	1.8%	16	1.4%
Unemployed	1,004	73.0%	996	73.6%	938	76.7%	875	78.8%
Disabled	182	13.2%	173	12.8%	167	13.6%	154	13.9%
Employed - Full-Time	110	8.0%	96	7.1%	64	5.2%	44	4.0%
Employed - Part-Time	24	1.7%	22	1.6%	14	1.1%	6	0.5%
Homemaker	4	0.3%	2	0.1%	2	0.2%	3	0.3%
Retired	22	1.6%	23	1.7%	12	1.0%	5	0.5%
Other	5	0.4%	2	0.1%	4	0.3%	7	0.7%
<b>Race:</b>								
White	1,174	85.4%	1,124	83.1%	1,023	83.6%	906	81.6%
Black/African American	141	10.3%	150	11.1%	151	12.3%	147	13.2%
American Indian	30	2.2%	34	2.5%	18	1.5%	24	2.2%
Asian/Pacific Islander	8	0.6%	11	0.8%	10	0.8%	11	1.0%
Bi-Racial	4	0.3%	13	1.0%	9	0.7%	12	1.1%
Other	11	0.8%	15	1.1%	8	0.7%	7	0.6%
Not Reported	7	0.5%	6	0.4%	4	0.3%	3	0.3%
<b>Hispanic Origin:</b>								
Yes	40	2.9%	49	3.6%	40	3.3%	38	3.4%
No	1,335	97.1%	1,304	96.4%	1,183	96.7%	1,072	96.6%

	FY2002		FY2003		FY2004		FY2005	
	N	%	N	%	N	%	N	%
<b>Legal Status at Admission:</b>								
Voluntary	143	10.4%	122	9.0%	112	9.2%	119	10.7%
Court Order	138	10.0%	142	10.5%	105	8.6%	121	10.9%
Mental Health Board Commitment	1,045	76.0%	1,061	78.4%	983	80.4%	847	76.3%
EPC	43	3.1%	26	1.9%	6	0.5%	16	1.4%
Other	6	0.4%	2	0.1%	17	1.4%	7	0.6%
<b>Diagnosis (Axis I Primary):</b>								
Schizophrenia	437	31.8%	430	31.8%	422	34.5%	401	36.1%
Substance Abuse (alcohol/drugs)	185	13.5%	174	12.9%	151	12.3%	140	12.6%
Bipolar Disorder	165	12.0%	189	14.0%	145	11.9%	157	14.1%
Major Depressive Disorder	124	9.0%	106	7.8%	94	7.7%	83	7.5%
Other Psychoses	57	4.1%	55	4.1%	62	5.1%	37	3.3%
Sexual Disorder	126	9.2%	108	8.0%	92	7.5%	93	8.4%
Other	281	20.4%	291	21.5%	257	21.0%	199	17.9%

Prepared by Paula Hartig, July 20, 2005; Research and Performance Measurement; Financial Services Division; HHSS – Finance & Support

Below is the Demographic Overview of Mental Health Unduplicated Persons Served in FY2005 within the Nebraska community mental health programs for both adults and youth served from the Magellan Behavioral Health data.

Magellan Behavioral Health / Unduplicated Persons Served / All Persons	N	%
<b>TOTAL PERSONS SERVED / FY2005</b>	32998	
<b>By Age:</b>		
0-17 years	2262	6.85
18-20 years	2182	6.61
21-64 years	17847	54.09
65-74 years	164	0.50
75 + years	66	0.20
Unknown/Not reported	10477	31.75
<b>By Gender:</b>		
Male	19351	58.64
Female	13647	41.36
Not reported		0.00
<b>Employment Status:</b>		
Student	307	0.93
Unemployed	6766	20.50
Disabled	259	0.78
Employed - Full-Time	9095	27.56
Employed - Part-Time	4046	12.26
Homemaker	55	0.17
Retired	25	0.08
Other	12282	37.22
Unknown/Not reported	163	0.49

Magellan Behavioral Health / Unduplicated Persons Served / All Persons	N	%
<b>Race:</b>		
White	22643	68.62
Black/African American	2780	8.42
American Indian	1359	4.12
Asian/Pacific Islander	237	0.72
Alaskan Native	12	0.04
Other	1856	5.62
Unknown/Not reported	111	0.34
<b>Hispanic Origin:</b>		
Yes	2034	6.16
No	30634	92.84
Unknown/Not Reported	330	1.00
<b>Legal Status at Admission:</b>		
Voluntary	17699	53.64
Court Order	3246	9.84
Mental Health Board Commitment	913	2.77
EPC	5103	15.46
Other	3697	11.20
Not reported	2340	7.09
<b>By Services:</b>		
MH only	17912	54.28
SA only	14853	45.01
Dual only	503	1.52

**Criterion 2: Mental Health System Data Epidemiology**

**FY 2004 Nebraska MENTAL HEALTH PLAN**

**PERFORMANCE INDICATORS**

**GOAL:** To increase in the number of people receiving Mental Health Services.

**OBJECTIVE:** To increase by 5% the number of persons age 18 or older (unduplicated count) in FY2006

**POPULATION:** Adults receiving mental health services within the Nebraska Behavioral Health System (NBHS)

Performance Indicator	FY2004 Actual	FY2005 Estimated	FY2005 % Attained	FY2006 Target
Value: M H Services only	16,620	17,912		18,800

**Criterion 4: Targeted Services to Rural and Homeless Populations**

- Describes State's outreach to and services for individuals who are homeless;
- Describes how community-based services will be provided to individuals in rural areas

**Criterion 4: Homelessness**

**NEBRASKA HOMELESS ASSISTANCE PROGRAM AWARDS**

The Nebraska Department of Health and Human Services (HHS) administers the Nebraska Homeless Assistance Program (NHAP). The purpose of the NHAP is to provide an overall "Continuum of Care" approach to address the needs of people who are homeless and near homeless in Nebraska, by:

- Assisting in the alleviation of homelessness,
- Providing temporary and/or permanent shelters for persons who are homeless,
- Addressing the needs of the migrant farm workers,
- Encouraging the development of projects that link housing assistance programs with efforts to promote self-sufficiency.

NHAP is a grant program consisting of the Nebraska Homeless Assistance Trust Fund (HSATF) and the Department of Housing and Urban Development (HUD) Emergency Shelter Grant (ESG). There are \$2.55 in state HSATF funds matching each federal ESG dollar. The intent of the HHS is to award these funds through a regional and programmatic activity specific allocation process. Organizations are encouraged to seek other sources of funding and collaborate and coordinate programs and services with other organizations to optimize the use of NHAP funds.

On July 5, 2005, the Department of Health and Human Services (HHS) has announced Nebraska Homeless Assistance Program Awards of \$2,795,239 to 66 community programs to address the needs of people who are homeless in Nebraska. These programs provide direct help to people in Nebraska who are homeless or close to being homeless," said Nancy Montanez, director for HHS. "No area of the state is exempt from these concerns, and the money is spread across the state to make as big of an impact as possible."

The funds are from the federal Emergency Shelter Grant Program (ESGP) of the Department of Housing and Urban Development and the state Homeless Shelter Assistance Trust Fund (HSATF). Federal Emergency Shelter Grant funds are awarded directly to Omaha, an entitlement city. HHS administers the Emergency Shelter Grant Program for the balance of the state and Lincoln, and administers the Homeless Shelter Assistance Trust Fund for the entire state. Money in the state trust fund is based on a 25-cent set-aside on each \$1,000 of the value of real estate sold in Nebraska, and is collected through the documentary tax stamp on real estate sales.

An allocation formula developed two years ago by HHS and the program's advisory committee insures an equitable distribution of funds to the seven regions in the state. The formula is based on a base amount, poverty tables, population, and HUD allocation factors. The formula is calculated annually to adjust for changes in population, distribution of poverty, and HUD

allocation factors. These are renewal awards and the second year of a two-year grant cycle. Renewal is based on formula adjustments, grantee performance, and participation in the regional continuum of care planning process that ensures there is collaboration and little duplication of services.

The grants provide emergency shelter and temporary housing, address needs of homeless migrant farm workers, link housing assistance with programs to promote self-sufficiency, and prevent homelessness. NAF Multicultural Human Development Corporation was funded at the state level, as it is a statewide organization that serves migrant and seasonal farm workers, minorities and other disadvantaged persons.

Grant awards for 2005 are listed below and include Emergency Shelter Grant funds to Lincoln and Omaha and the balance of the state, and Homeless Shelter Assistance Trust fund dollars: North Central Region (\$299,104); Southwest Region (\$277,194); Southeast Region (\$468,690); Northeast Region (\$374,565); Lincoln (\$388,360); Omaha (\$793,254) and NAF-Statewide organization (\$ 11,000). For more information contact Jean Chicoine, HHS Office of Economic and Family Support, (402) 471-9644, [jean.chicoine@hhss.ne.gov](mailto:jean.chicoine@hhss.ne.gov) Or visit the HHSS web site <<http://www.hhs.state.ne.us/new/0705nr/homeless.htm>>

#### **Projects for Assistance In Transition from Homelessness (PATH)**

The Nebraska Department of Health and Human Services contracts with the Regional Behavioral Health Authorities §71-809 Neb. Rev. Stat. 1943 for delivery of community mental health services including contracts for the implementation of PATH Formula Grant activities.

- Service Areas: Based on the evidence of need, the two primary geographic areas within Nebraska receiving most of the PATH funds are Lincoln (in Region 5) and Omaha (in Region 6). This is based on the fact that Lincoln and Omaha have the greatest numbers of homeless individuals in Nebraska. PATH funds will also be allocated in two other locations in the state: Scottsbluff (in Region 1) and Grand Island (in Region 3).
- Services to be supported by PATH Funds: The PATH programs will provide outreach, screening and diagnostic treatment services, case management, referral, some temporary housing assistance, and other appropriate services to individuals who are suffering from serious mental illness or are suffering from serious mental illness and from substance abuse, and are homeless or at imminent risk of becoming homeless.
- Number of Persons to be served: The estimated number of persons that will be served in FY05 statewide is 958.

#### **Organizations to Receive Funds and Amounts Allocated (FY2005):**

Region 1 – Western Nebraska Scottsbluff	Cirrus House: (Private non-profit entity)	\$11,333	4%
Region 3 – Central Nebraska Grand Island	Central Nebraska Goodwill Industries, Inc. (Private non-profit)	\$11,333	4%
Region 5 – Southeast Nebraska Lincoln and Lancaster County	Community Mental Health Center/Lancaster County (Public, County Governmental Entity)	\$32,500	11%
	CenterPointe, Inc. (Private, non-profit)	\$32,500	11%
Region 6 – Eastern Nebraska Omaha and Douglas County	Community Alliance (Private, non-profit)	\$147,213	51%

	Salvation Army (Private, non-profit)	\$53,121	18%
TOTAL		\$288,000	100%

**Criterion 4: Describes how community-based services will be provided to individuals in RURAL AREAS**

**(i) Current Activities**

Using 2000 Census data, 899,838 (52.6%) of the 1,711,263 residents in Nebraska live in six (6) counties classified as Metropolitan Areas. That means there are 811,425 (47.4%) residents who live in Micropolitan (10,000 to 49,999 residents), Rural or Frontier (less than 7 persons/sq.mi.) areas. Most of this Federal Mental Health Block Grant application has been addressing how community-based services are provided. From the Nebraska Division of Behavioral Health Services point of view, the same general approach is used within each geographic area including the rural areas.

Regional Behavioral Health Authorities (RBHA) exercise “local control” in partnership with the State of Nebraska. This local control is very important due to the challenges of providing services in each of these four types of geographic areas (Metropolitan, Micropolitan, Rural or Frontier). There must be flexibility in delivery/provision of “accessible” mental health services in each of these four types of areas. In addition to the services offered via the RBHAs, there is one specialized rural mental health program Nebraska funds through the Division of Behavioral Health Services. It is the Rural Mental Health Voucher Program.

Rural Mental Health Hotline and Voucher Program: This program provides crisis counseling services to the rural residents of Nebraska. The demand for these services has continued to increase as those who derive their livelihood from the rural economy continue to face the stress of low prices, increased costs, and drought. Rural residents calling the toll-free Nebraska Farm Hotline (1-800-464-0258) who present to be in need of professional mental health treatment are informed of the “Voucher Program”. The “Voucher Program” is designed to make cost-free, confidential mental health counseling available to persons affected by the current rural farm crisis. The program is not limited to farmers. Any rural resident who is negatively impacted by the rural crisis may apply. This includes farm family members, those employed in agriculture-related businesses, small town businesses dependent on the agricultural economy, and other rural residents.

Upon request from the caller, Farm Hotline staff mails a voucher with a list of mental health providers in the caller’s geographic area and provider contact information. Each voucher pays for one outpatient session. The caller has 30 days to redeem the voucher by receiving counseling from an approved provider of their choice on the list. If more than one session is needed, up to 5 additional vouchers for therapist prescribed sessions can be obtained by calling the Hotline. Additional sessions, if needed, are often provided free by the provider as the need in the rural/frontier areas is critical. Mental health providers are reimbursed at the rate of \$60.00 for each 50-60 minute session provided.

Currently, 211 licensed (a requirement) mental health providers in every part of the state have signed on to provide services under the Voucher Program. As of June 30, 2005, 82 providers were currently active. A large number of providers have strong agricultural backgrounds and an understanding of rural culture. The voucher program is managed on a per month allotment so the program will have funds for the entire year. For FY 2006, the funding to the "Rural Mental Health Crisis Counseling Program" is \$152,440.

**Criterion 4: Targeted Services to Rural and Homeless Populations**

- Describes State's outreach to and services for individuals who are homeless;
- Describes how community-based services will be provided to individuals in rural areas

**(ii) Goals, Targets and Action Plans**

**GOAL:** With the Rural Mental Health Program, provide services to the rural residents of Nebraska impacted by the prolonged decline of the farm/rural economy in Nebraska.

**OBJECTIVE:** In FY2006, provide 3000 counseling sessions to 1000 people (individuals or families) under the crisis counseling vouchers program.

**POPULATION:** Residents of Nebraska's rural and frontier areas including farmers, ranchers, spouses, children, and others who are directly affected by the continued economic crisis.

Value: average number of sessions per individual/family

Numerator: unduplicated count / people served (individual or family)

Denominator: total number of counseling sessions

Performance Indicator:	FY2003 Actual	FY2004 Actual	FY2005 Actual	FY2006 Target
Value:	2.5	3.14	2.13	3.0
Numerator	800	901	819	1000
Denominator	2000	2834	1743	3000

**Discussion:** In FY 2005, \$104,247.94 was expended for the Rural Voucher Program. The demand for vouchers increased significantly in rural Nebraska early in the year (1104 vouchers were redeemed in the first 3 months). A contract amendment adding more funding was completed in March, 2005 to address the need. Since the vouchers had to be rationed earlier in the year, the funding is going to be increased this year at the beginning of the contract with the expectation that most of the rural mental health counseling needs/requests will be met throughout the year. Of the 1,743 vouchers redeemed for counseling services, 219 were for youth under the age of 18 years.

Data source: from Nebraska Division of Behavioral Health Services

**Criterion 5: Management Systems**

- Describes financial resources, staffing and training for mental health services providers necessary for the plan;
- Provides for training of providers of emergency health services regarding mental health; and
- Describes the manner in which the State intends to expend the grant under Section 1911 for the fiscal years involved.

**(i) Current Activities**

Criterion 5 - Describes financial resources, staffing and training for mental health services providers necessary for the plan

See SECTION III – STATE PLAN / A. Fiscal Planning Assumptions for Adults and Children for details on

- Describes financial resources
- Describes the manner in which the State intends to expend the grant under Section 1911 for the fiscal years involved.

**NOTE: this material applies to both Adults and Youth.**

**- Criterion 5 - staffing**

In August 2005, the Division of Behavioral Health Services. At this time, there are 12 professional staff, plus Prevention Professional staff, support FTE and student interns (part-time). All staff have a variety of job duties. Ron Sorensen is the Behavioral Health Administrator. Barb Thomas is the Assistant Director. The Field Representative are Sue Adams (Regions 1 & 2), Kathi Samuelson (Region 4), Linda Wittmuss (Region 5), and Dennis Snook (Region 3 & 6). Phyllis McCaul and Dan Powers are the Consumer Liaisons. Jim Harvey assignments include addressing the Mental Health Block Grant requirements. Bob Bussard assignments include addressing the Substance Abuse Block Grant. Gordon Tush works on the Compulsive Gambling program. Lisa Franz in has duties that include working with the Regional Centers.

Effective October 3, 2005, Mary Jane Strong, APRN, MS, BC, will begin as Deputy Administrator for the Division of Behavioral Health Services. Mary Jane Strong currently serves as Program Director of the Psychiatric Clinical Research Center at Rush University Medical Center in Chicago, Illinois. Previous experience includes administration of a complex academic research program at the University of Illinois at Chicago and as a nurse manager for a psychiatric inpatient unit and an adolescent and older adult inpatient unit. She has a Bachelor of Science - Nursing degree and a Master of Science - Nursing Administration and Psychiatry degree, both from St. Xavier University in Chicago, Illinois.

**NOTE: this material applies to both Adults and Youth.**

**- Criterion 5 - training**

NAMI- NE is to develop an infrastructure for a mental health education, support and advocacy presence in Nebraska and to provide specific family education , support, information, advocacy

and related functions for consumers of mental health services and their families in Nebraska. NAMI will be providing consumer sensitivity training to the staff at the three regional centers.

Mental Health Association of Nebraska is to develop a consumer sensitivity training of administrators and front line staff in Nebraska nursing facilities and assisted living facilities to assist them in their work with persons in their facilities who have mental illness or behavior.

Magellan Provider Training – Magellan Behavioral Health continues to provide training with all contract providers on managed care issues with the renewal of the ASO contractor effective January 1, 2000.

The Department will continue to sponsor trainings for consumers/providers covering the recovery concept. For example, the Department continues to support the Aurora, Nebraska conference designed to provide training to consumers. There are 100 consumers expected to participate in each year's conference. The Consumer Conference is usually held in September.

Suicide Prevention Curricula being delivered via a train the trainers model. This model develops and maintains local expertise in suicide prevention. The target population for this pilot was adults in Southeast Nebraska with emphasis on reaching those at highest risk for suicide. For more information, see ADULT GOAL #3: SUICIDE PREVENTION INITIATIVE.

### **Training for the Mental Health Boards**

Criterion 5 - Provides for training of providers of emergency health services regarding mental health

The Department of Health and Human Services (HHS) is responsible for training of Mental Health Boards under Neb. Rev. Stat. §71-916. There are approximately twenty-eight mental health boards across the state.

The 2005 training will be provided by the Division of Behavioral Health Services. The training packet will consist of protocols/procedures/timelines for outpatient and inpatient commitment, forms to be used in the commitment process, and definitions of Mental Illness and Substance Dependency. The participants invited to the FY06 training will be members and alternate members of the Boards of Mental Health. The training will be specific to topics listed as a priority on a questionnaire mailed to every Board member in the state. The Nebraska training for 2005 will be held either by teleconference or at a regional location in all 6 regions (up to 10 sites).

Under §71-916 (1), HHS shall provide appropriate training to members and alternates of each Mental Health Board. HHS shall consult with consumer and family advocacy groups in the development and presentation of such training. The section says no person shall remain on a Mental Health Board or be eligible for appointment or reappointment as a member or alternate of such board unless he or she has attended and satisfactorily completed such training pursuant to rules and regulations adopted and promulgated by HHS.

The Mental Health Commitment Boards play a key role in Nebraska. Sections 21 to 82, 88-89, and 126 of LB 1083 amended and updated the "Nebraska Mental Health Commitment Act". One of the aspects of the Nebraska Mental Health Commitment Act includes the proceedings of the Mental Health Boards.

One of the starting points for the commitment cycle is with an emergency protective custody (EPC). If a Law Enforcement Officer has probable cause to believe that a person is mentally ill and dangerous and the harm is likely to occur before a Mental Health Board proceedings can be arranged, the Officer may take such person into emergency protective custody (EPC). The person shall be admitted to the nearest appropriate and available medical facility and shall not be placed in a jail. The medical facility shall complete an evaluation by a mental health professional of the person no later than thirty-six hours after admission. The person shall be released from the EPC after completion of such evaluation unless the mental health professional determines, in his or her clinical opinion, that such person is mentally ill and dangerous.

The County Attorney receives a copy of the evaluation. If the County Attorney concurs that such person is mentally ill and dangerous and that neither voluntary hospitalization nor other treatment alternatives less restrictive of the person's liberty than inpatient or outpatient treatment ordered by a Mental Health Board is available, he or she shall file a petition. The petition is for a hearing by the Mental Health Board. The hearing needs to be held within seven calendar days after the person has been taken into emergency protective custody.

The hearing is held by the Mental Health Board to determine whether there is clear and convincing proof evidence that the subject is mentally ill and dangerous as alleged in the petition filed by the County Attorney. Treatment may be ordered by the Mental Health Board. Such services shall represent the appropriate available treatment alternative that imposes the least possible restraint upon the liberty of the person. If the Mental Health Board finds the subject to be mentally ill and dangerous and commits the subject to the custody of the Department of Health and Human Services to receive inpatient treatment, the Department shall secure placement of the subject in an appropriate inpatient treatment facility to receive such treatment.

Disaster Mental Health Training - HHS has established an intergovernmental agreement with the University of Nebraska Public Policy Center to develop an All-Hazards Disaster Behavioral Health Response and Recovery Plan for the State of Nebraska. The goal is to develop human infrastructure in Nebraska to effectively mitigate or respond to the psycho-social consequences of terrorism and disaster. This includes fostering links between mental health/substance abuse resources including the six Regional Behavioral Health Authorities (Neb. Rev. Stat. §§ 71-807 to 71-809) and public health systems, healthcare networks, emergency management, and first responder groups. Stakeholders from across the State and across disciplines are involved in this project. Community groups, faith groups, public and private entities and key responders like the American Red Cross, Nebraska's Critical Incident Stress Management Team, and Nebraska State Agencies are all collaborating with the Public Policy Center in this endeavor. For more information see <<http://www.disastermh.nebraska.edu/>>

As a result of this work, the Nebraska Behavioral Health All-Hazards Disaster Response and Recovery Plan was formally adopted by the Nebraska Department of Health and Human Services on January 20, 2005 [see <http://www.disastermh.nebraska.edu/plan.shtml>].

The University of Nebraska Public Policy Center has prepared, with the University of Nebraska Medical Center, a curriculum on "Psychological First Aid". This is being used to prepare school personnel, healthcare professionals, faith leaders, and other natural helpers to augment the professional behavioral health response to terrorism and disaster. The Nebraska Psychological First Aid Curriculum has been used to train over 400 people across the State of Nebraska during the Spring of 2005. In addition, each Regional Behavioral Health Authority has now received training for local trainers. As a result, each Region has local capacity to provide Psychological First Aid training in their local area. The curriculum is posted on the NE Disaster Behavioral Health web site [see <<http://www.disastermh.nebraska.edu/education.shtml>>].

NEBRASKA DISASTER BEHAVIORAL HEALTH CONFERENCE was held on July 14-15, 2005 in Omaha, NE. There were 193 participants for the conference. On July 15, 2005, the Opening Remarks were made by the Lieutenant Governor of Nebraska, and director of homeland security, Rick Sheehy.

#### Conference Objectives were

- Recognize opportunities to improve cultural competence in service delivery following a disaster or critical incident
- Explore intervention strategies appropriate for use with children following a disaster or critical incident
- Identify the post-disaster needs of people who have experienced past trauma (e.g. war, abuse)
- Examine the role of mental health in risk communication

#### Conference Faculty and topics were:

- Elspeth Cameron Ritchie, M.D., J.D. - Department of Psychiatry, Uniformed Services University of the Health Sciences. Topic: "Assessment and Mitigation of Psychological Reactions to Disaster, Terrorism and War"
- Bruce Young, LCSW - Disaster Services Coordinator, National Center for Post Traumatic Stress Disorder. Topic: "A Way of Change: An Integrated Cognitive-Behavioral Approach"
- Kermit Crawford, Ph.D. Director of the Center for Multicultural Mental Health (CMMH), Division of Psychiatry, Boston University School of Medicine/Boston Medical Center. Topic: "Disaster Substance Abuse Treatment: The Myth, Method and the Reality"
- Rabbi Manis Friedman - Dean, Chana Institute of Jewish Studies. Topic: "The Care and Treatment of Observant Jews in a Time of Crisis"
- Ron Edmond - Senior Technical Specialist, Oak Ridge Institute for Science and Education. Topic: "Risk and Crisis Communication"
- Elaine Enarson, Ph.D. - Lecturer, Sociology and Women's Studies, University of Colorado Boulder. Topic: "Gender and Disaster: Making the Connection in Practice"
- Malia Robinson, Ph.D., Independent Consultant who has worked in Africa managing and advising psychological support programs for children affected by armed conflict. Topic: "Focus on Resiliency in the Psychosocial Support of Children in Crisis"

- A Panel Discussion with Moderator: Denise Bulling, with panel members involved in the response and recovery from those event Leslie Crawford, Rose Esseks, Rev. Gwen Hurst-Anderson, and Rev. Lorri Kentner. Topic: "Lessons Learned from Nebraska: The Southeast Nebraska Tornado (May 2004)".

#### Critical Incident Stress Management

Critical Incident Stress Management (CISM) Program is a key resource for Nebraska's capacity to provide mental health disaster response services. The CISM program is authorized by the "Critical Incident Stress Management Act (Neb. Rev. Stat. §§ 71-7101 to 71-7113)". There are five State of Nebraska Departments sponsoring this program: Department of Health and Human Services Regulation and Licensure / Emergency Medical Services (EMS) Program; Department of Health and Human Services / Division of Behavioral Health Services; Nebraska State Patrol; State Fire Marshal and the Nebraska Emergency Management Agency. Please note that Division of Behavioral Health Services staff serves on the CISM Interagency Management Committee.

The Nebraska Critical Incident Stress Management Program trains volunteers to provide crisis support to reduce the harmful effects of critical incident stress for; law enforcement officers; firefighters; emergency medical services, corrections, hospitals, and emergency management personnel; and dispatchers. There is an annual conference (first weekend after Memorial Day) where a lot of training on mental health disaster related topics occurs.

The core functions of the Nebraska Statewide Critical Incident Stress Management Program are: Recruitment and retention of volunteers (training, continuing education); Intervention services (defusings, debriefings, referral); and Prevention (education, consult agencies). For more information on this program see <<http://www.hhs.state.ne.us/ems/emscism.htm>>.

#### **(ii) Goals, Targets and Action Plans**

Criterion 5: Management Systems / FY2006

**GOAL:** Increase the Per Capita State Expenditures for Community Mental Health Services

**OBJECTIVE:** By June 30, 2006, the per capita state expenditures for community mental health services will be increased to over \$22.00.

**POPULATION:** Total population

#### **Per Capita State Expenditures for Community Mental Health Services**

Numerator = "actual" Mental Health State Expenditures (as reported for the Maintenance of Effort section of the Block Grant Application)

Numerator Data source: Division of Behavioral Health Services

#### **Denominator = Total State population**

Data Source: Nebraska Databook, Last Updated on 5/21/01 based on data from U. S. Bureau of the Census Web site ([www.census.gov](http://www.census.gov)) 2001 <<http://info.neded.org/stathand/bsect8.htm>>

Performance Indicator	FY 2003 Actual	FY2004 Actual	FY2005 Target	FY2005 Actual	FY2006 Target
Value:	\$16.97	\$20.85	\$21.60		\$22.49
Numerator	\$29,036,852	\$35,678,871	\$36,970,889		\$38,488,846
Denominator	1,711,263	1,711,263	1,711,263		1,711,263

### **SECTION III – STATE PLAN**

#### **CHILDREN’S PLAN**

#### **Section II – Children State Plan Context**

##### Children Goals

- A. State public mental health service system as it is envisioned for the future
- B. Previous State plan
- C. The State’s Priorities and Plans to Meet Unmet Needs

#### **SECTION II – STATE PLAN CONTEXT – Children and Families Section**

##### **A brief description of the state public mental health service system (for children and adolescents) as it is envisioned for the future**

Based on data which indicates areas of need, the state has the ability to plan for a public mental health system in which all children with mental health needs have access to a comprehensive, integrated system of care that meets the following principles:

- Community based, with the locus of services as well as management and decision making responsibility resting at the community level.
- Culturally competent, with agencies, programs and services that are responsive to the cultural, racial, and ethnic differences of the populations they serve.
- Provide access to a comprehensive array of effective services that address the child’s physical, emotional, social, and educational needs.
- Individualized services in accordance with the unique needs and potentials of each child that is guided by an individualized support plan.
- Provision of early identification and intervention in order to enhance the likelihood of positive outcomes.
- An array of services which support youth.

The desired outcome for the children’s public mental health system is to move from a fragmented system to an integrated system. Funding agencies, in conjunction with families, providers and communities, coordinate policy development, needs assessments, planning, service development, funding, program evaluation, utilization management, information management, and quality improvement. Families are organized to support and advocate for one another and are included at every level of decision making. Service providers are joined in a network to coordinate care and to ensure services are high quality. Communities organize resources and

supports to help children and families. All youth with Serious Emotional Disturbances will receive services which enhance their ability to transition successfully into adulthood with minimal disruption in service and maximum success potential.

**Statewide Effort to Meet All Goals** The following describes Nebraska's efforts to strategically plan for systems of care for mental health of children in our state. Because of the magnitude of this effort, we have described this grant first since it does effectively strive to reach all of the goals proposed below:

Nebraska has been awarded a Children's Mental Health state infrastructure grant to support systems of care at the state level. Although some Nebraska communities have developed comprehensive, integrated systems of care that provide exceptional services for children and families, these efforts are islands of excellence in a troubled sea. The State has significant challenges in appropriately addressing the behavioral health needs of its children and their families. Vast areas of the state are frontier and rural and have severe shortages of mental health and substance abuse professionals. Of Nebraska's 93 counties, 86 are designated psychiatric shortage areas. Even when services are available, families have difficulty affording behavioral healthcare; Nebraska has seven of the 12 poorest counties in the nation. According to an Omaha World Herald exposé on children's mental health, one in four families of children with serious mental health problems were encouraged to relinquished custody of their child just to access behavioral healthcare that they could not afford and Nebraska has the highest number of children per capita in the country who are wards of the state. Nebraska has a growing population of ethnic/racial minorities; these populations present unique behavioral health needs that the current system is ill prepared to meet. Other challenges include fragmentation across systems, lack of evidence-based services, and funding structures that are not supportive of individualized, family-centered care.

Specifically, the State Infrastructure Grant application proposes to help expand wraparound across systems, develop service models for challenging populations (children ages birth through 5, transition-aged youth, and youth with co-occurring substance abuse and mental health disorders), establish culturally and linguistically appropriate practices, and create a forum for state agencies to work with stakeholders to develop an integrated, family-centered behavioral healthcare system for children and families. A wide array of stakeholders are committed to this project including the state agencies responsible for mental health, substance abuse, Medicaid, child welfare, juvenile justice, education, vocational rehabilitation, public health, and developmental disabilities. The need for infrastructure development identified in this application is wholly consistent with the priorities of Nebraska. Through the leadership of the Governor and the Legislature's Health and Human Services Committee, Nebraska enacted major legislation this spring designed to ensure access to behavioral health services, create an appropriate array of community-based services and a continuum of care, coordinate behavioral healthcare with primary healthcare services, develop services that are research based and consumer focused, ensure consumer involvement as a priority in all aspects of service planning and delivery, and develop funding that is fully integrated and supports a plan of treatment.

### **Children's Goal #1: Strategic Planning**

#### **The state service system as it is envisioned for the future:**

To implement a data based strategic planning process which supports a comprehensive service system for all children with serious emotional disturbances and their families, through early childhood to their transition to adulthood.

#### **Previous State Plan**

Services in the public system are primarily available to specific target groups, including children who are state wards, children who are involved in the legal system, and children whose families have no insurance or financial resources. This gap in service exists primarily because the need is great and funding resources are limited. Therefore, funds have been targeted to provide services for very specific groups of children and their families. However, we believe it is prudent to revisit these gaps on a periodic basis to determine if services have been increased to these populations, and to make adjustment in the expansion of targeted populations based on current needs as supported by data.

#### **The States Priorities and Plans to Meet Unmet Needs**

Statewide efforts:

Nebraska has applied for a SAMHSA Suicide **Prevention Grant**. Suicide is a major public health concern in Nebraska. Over the past ten years suicide has consistently ranked among the top ten causes of death in the United States and in the top ten causes for all Nebraskans. Suicide consistently ranks as the second leading cause of death in males ages 1-19 and 20-44 in Nebraska. Risk factors for suicide intersect with other societal issues such as mental health, drug and alcohol use, unemployment, cultural identity, and poverty. In Nebraska, rural residents and those in underserved communities face additional barriers, such as lack of access to mental health services and general lack of health care providers.

In 2003, 175 Nebraskans committed suicide. Thirty-two (32) of these deaths or 18 percent were youth victims between the ages of 10 and 20. During the years 1999-2003, suicide hospitalization rates for 15-19 year olds and 20-24 year olds were higher than the rates for the total population.

Results from the 2003 Youth Risk Behavioral Survey Results for Nebraska revealed that 9 percent of youth surveyed (grades 9-12) attempted suicide during the past year, which is higher than the overall United States average of 8.5 percent. The 2003 Youth Risk Behavior Survey of Nebraska Public High School Students reported that 31.6 of females and 19.2 of the males surveyed felt sad or hopeless. Twenty-four (24) percent of the females and 12.2 percent of the males surveyed reported seriously considering committing suicide. Twenty (20.1) percent of the females and 14.5 percent of the males surveyed had made a suicide plan. 4 (is this number significant?)

The purpose of the Nebraska Youth Suicide Prevention Project is to promote mental health awareness and well-being and to prevent suicide. The goals of the Nebraska Youth Suicide

Prevention Project are to: create an infrastructure and workplan for implementation of the Nebraska Youth Suicide Prevention Project; Expand Project Relate, existing suicide prevention social marketing efforts in the state, to focus on youth suicide prevention; Promote continued and expanded use of the Suicide Prevention Curriculum developed by the State Suicide Prevention Committee (NSSPC) for the Southeast Nebraska Suicide Prevention Project; Provide community-wide crisis management training and support for schools, law enforcement, faith-based communities, and other community and family support organizations dealing with a loss as a result of suicide; Create a referral network of Primary Care Physicians and Mental Health Services Providers to immediately assist at-risk youth and their families and to provide continuity of care; Partner with juvenile correctional, detention, and out of home placement agencies across the region to adopt and utilize the Greenline Suicide Prevention Program to train facility staff on youth suicide prevention;

Partner with the School Community Intervention Program (SCIP) at the Lincoln Medical Education Partnership to increase the number of schools participating in the SCIP Program and to increase the number of providers offering free SCIP Screenings to youth. One current provider is using one of the TeenScreen computerized tools as their means of SCIP screening. While recruiting additional providers it will also be crucial to introduce them to the TeenScreen as a means of screening youth;

Enhance the ability of hotlines to appropriately assess and intervene with youth who are suicidal or depressed.

Additionally, the Nebraska Health and Human Services System proposes to develop a **transition project for young adults with disabilities**, the ultimate *goal* of which is to improve access to adult-focused tertiary and specialized medical care for SSI-eligible youth transitioning from EPSDT to adulthood. This \$500,000 three-year project will implement a *four-pronged approach* to achieve this goal: (1) Develop an amendment to Nebraska's Home and Community-Based Aged and Disabled Waiver to modify the assessment process used for persons transferring from children's services to adult services, to include a medical transition component; (2) Coordinate training for general practitioners so they are ready to serve young adults on the Waiver, and cultivate relationships between them and pediatric specialists who have been serving these persons in their youth; (3) Implement a pilot project with a rural school district that will integrate medical transition assessment and planning into required transition plans for employment preparation; and (4) Create a transition clinic as part of the Medically Handicapped Children Program's specialty clinics, specifically for SSI-eligible youth as they age out of children's services.

#### **Local efforts:**

Southeastern Nebraska: Local behavioral health authority staff facilitate and/or participate in a number of ongoing strategic planning efforts related to youth services. Below is a list of some of these activities

- Children's Level Of Care Meeting - Region V Systems hosts a monthly Children's Level of Care Meeting to facilitate youth providers in addressing systems issues, case discussion, and agency sharing. We are planning to identify one or two key indicators for youth services to measure during FY 05-06.

- Culturally and Linguistically Appropriate Services (CLAS) Coalition – Region V Systems hosts a monthly coalition to address cultural and linguistic needs in behavioral health. This is not youth specific but there are many youth providers who participate.
- Youth Action Board – The Regional Prevention Center coordinates the Youth Action Board which focuses on prevention activities, particularly in the rural areas of the region. This group organizes leadership retreats, the drug-free Tailgate Party at UNL's Red/White Game, and June Jam, an annual 2-day youth retreat.
- Families First and Foremost Stakeholders – Region V Systems participates in the Families First and Foremost Stakeholders group which steers that project to implement a System of Care for youth in Lancaster County.
- Youth Specialist Community Involvement – The Youth Specialist participates in a variety of community groups addressing youth needs. These include the Truancy Task Force, the Lancaster County Juvenile Justice Team, and The HUB
- Region V Systems in partnering with the Human Services Federation to facilitate the Community Services Initiative (funded in part by the United Way and the Lincoln/Lancaster County Joint Budget Commission). There are four major coalitions as part of this ongoing planning and analysis. Early Childhood, Education, and Youth Development is one of those coalitions. As of June 2005 this group is coordinating the Mayor's Youth Summit "One Vision, One Voice" to create a comprehensive vision for the youth of Lincoln.
- The Region V Systems / Human Services Federation collaboration also oversees the coordination of the Midwest BEST "Advancing Youth Development" Trainings. The community has four people who have been trained as trainers and the 3-day training is offered free on an ongoing basis utilizing grant funding.

Northeastern Nebraska: Each year the Professional Partner Program has had a strategic planning day which ensures the recognition of both the gaps and the strengths of services for youth with serious emotional and behavioral disturbances and their families within the Region 4 service delivery area. Data is currently being collected by the Prevention Center (Prevention Pathways) for the SCIP Program. In addition, several area schools have been using the Student Risk Survey to determine areas of immediate needs. In response to the results of these surveys, two area school districts have opted to apply for the Safe Schools/Health Students Initiative which would provide a variety of services to youth in need of multiple services. In both of these schools the Region has been active in submitting data and working in conjunction with various community partners and the AIM Institute on completing the grant process for the past two years.

The Northeast Nebraska Integrated Care Coordination Units (ICCU) has been proactive in determining needs and strengths of our current child serving system and is determining the next steps in developing a Prevention Program aimed at diverting children and their families from entering the HHS by reinvesting savings from the current ICCU program.

The Regional Youth Specialist continues to be active on the community teams that pertain to youth with serious emotional disturbances and their families.

In Eastern Nebraska, several individuals in the Omaha area are providing leadership to start a Nebraska Infant Mental Health Association. The goal of the organization is to focus on the well-being of infants and those children age 3 and younger. Also interested in the younger children and their families is the Coalition for the Advancement of Children's Mental Health. This coalition is a collaborative effort of schools, private and public agencies and therapists, for-profit and non-profit agencies, family advocacy groups, and medical personnel. The CACMH is working with local agencies to provide training to mental health therapists who wish to increase their knowledge and skills in working with children age 5 and younger and their families. Also in the starting stage is a case consultation component for therapists. Training is beginning for childcare providers to help them handle difficult behaviors and to spot potential problems. Additionally, the CACMH is looking at establishing a data base for "Frequently Asked Questions," resources, and therapists who specialize in young children's issues. The Ralston Early Childhood Commission is also looking at ways to reach families of young children and offer them support. They have instituted a family night at one of the schools and activities at the public library. There is a great deal of interest in seeing how the passage of LB264 will impact locally. The Metro Child Advocacy Coalition would like to help work with HHS in planning and in making suggestions on implementation strategies.

The Douglas County Juvenile Assessment Center has been in operation for just over a year now. They are screening youth who have had contact with law enforcement for mental health problems and substance abuse as well as making referrals. This has been effective in identifying youth who need services and are more appropriate for diversion. The Sarpy County Juvenile Justice Center is trying to start a day reporting center and a wellness program for youth involved with the juvenile court system. The juvenile judges are also pushing for a youth drug court.

The LB1184 teams in each county are getting more organized and are looking more in depth at the treatment needs of the youth in care as well as their families. They are looking at placement issues and asking questions about the best placement for the youth. The treatment teams are asking case managers to plan for permanency.

Agencies have been asking for support from the region as they apply for grants. Programs being considered are a Child Trauma Center for children who have been victims of domestic violence, child abuse, witnessed a crime, or been involved in a disaster or other traumatic event. Another agency is trying to start after school programs in schools which contain a higher number of at-risk children.

In summary, these new projects were proposed/developed to provide mental health and other supports for children and their families within targeted populations, and to change the way the state supports local efforts.

### **State Children's Goal #2: Family Support**

State Service System as it is envisioned for the Future:

The goal is to support comprehensive, community-based family peer mentoring for families of children with emotional, behavioral, and mental health issues.

- Support is child centered and family focused, with the needs of the child and family dictating the types and mix of services provided.
- Services are within the least restrictive, most normative environment that is clinically appropriate.
- Families and surrogate families should be full participants in all aspects of planning and delivery of services.
- Family organizations receive support from multiple initiatives, increasing financial viability

### **Previous State Plan**

FY03 Goal #1: To provide comprehensive, community-based family support for families of children with emotional, behavioral, and mental health issues.

### **The State's Priorities and Plans to Meet Unmet Needs**

New Projects involving the support of families include:

The Office of Protection and Safety and the Office of Mental Health, Substance Abuse and Addiction Services continues to fund the initiative, "Families Mentoring & Supporting Other Families," a joint initiative to request proposals from qualified sources which provides Strength-based, family centered, and partnership oriented supports to parents across the State of Nebraska whose children have been made state wards, or are in a voluntary case, or parents who are involved with the department as a result of a report of abuse/neglect, or parents whose children are diagnosed with a serious emotional disturbance and substance dependence disorders. The intent is to ensure that parents have a voice, ownership and access to the systems of care for their child (i.e. case plans, individual educational plans, treatment plans, and any other care plan).

The Department found organizations interested in working with the State to build support services to families that will focus on providing parents with an understanding of wraparound services through peer role modeling and coaching. The philosophy of wraparound includes individualized services that are developed through professionals and parents in partnership, where both are serving important roles in service delivery. Services are tailored to meet the individualized needs of the child and family based upon strength-based assessments.

The program objectives are to support one parent organization within each of the service areas/regions, for all individual parent organizations awarded contracts to come together and form a consortium so there is some commonality and consistency between the 6 service areas/regions organizations, and an opportunity for statewide issues to be addressed. HHS has a collaborative relationship with the consortium. The consortium members may be required to meet with HHS via telephone conference calls on a quarterly basis and in-person one to two times per year. They deliver parent to parent supports that are efficient, effective and responsive, that are tailored to the unique and individualized needs of the child and family, as well as measure and demonstrate the parent outcomes outlined above.

Supports provided to parents include:

- ◆ one on one mentoring and coaching of parents by other parents that have/are experiencing similar issues;
- ◆ contact with the family (frequency and type to be determined by the family) if the family chooses to have such home visits and/or phone calls;
- ◆ general advocacy and support (i.e. at child/family team meetings)
- ◆ training and empowerment resulting in effective working relationships with case managers, teachers, and other professionals;
- ◆ help identify family strengths to nurture positive team interactions
- ◆ education regarding parental rights and responsibilities as it relates to Nebraska HHS systems of care;
- ◆ assistance in interpreting the case plan, court documents, the Individual Educational Plan (IEP) process, medical documents and service/treatment plans;
- ◆ professional referral resources as appropriate per individual child/family needs. (i.e. navigating to other available resources and opportunities);
- ◆ coordinate volunteers to assist with parent supports.

In addition, NAMI –Nebraska has purchased the “Visions for Tomorrow” curriculum to provide education and support to families in southeast Nebraska. Visions for Tomorrow education workshops are designed for caregivers of children and adolescents who have been diagnosed with a brain disorder as well as those who exhibit behavior that strongly suggests such a diagnosis.

- i. There is no charge for the course for the caregivers.
- ii. Visions' teachers are caregivers themselves.
- iii. The course has been designed and written by experienced caregivers, family members, and professionals.
- iv. The course balances basic psycho-education and skills training with self-care, emotional support and empowerment.

#### Purpose

- To provide basic education and knowledge of various brain disorders
- To provide general information for networking with support groups and dealing with the different systems of care.
- To provide basic information and methods needed to advocate for persons with brain disorders.

#### Local efforts:

- In Southeastern Nebraska, Region V Systems works in conjunction with two major family support groups.
- Families Inspiring Families (FIF) – Region V Systems has partnered with FIF to allow for them to use office space and other business supports related to day-to-day operations. FIF has applied and received small grants from Region V Systems.
- Healthy Families Project (HFP) – Region V Systems has been a major stakeholder in the Families First and Foremost project and the Lancaster County ICCU. HFP is linked to these projects. HFP has also applied and received small grants from Region V Systems.

- In Northeastern Nebraska, The Regional Youth Specialist has worked directly with the Parent to Parent NETWORK Director and Board of Directors to ensure a seamless delivery system to the citizens of the Region 4 service delivery area. In addition to taking the lead on writing and subsequently being awarded funding, this position has served as both a Board member on the local and state level and was instrumental in developing the program which provides services today.

In Eastern Nebraska, the Region 6 area has been supportive of the wrap-around concept and the whole systems model with supporting the family and child and making services available by focusing on family identified needs. Professional Partners is well-received in this region and helps families with children who have a mental health diagnosis or behavior problems find their own supports and mentors. Through the Coalition for the Advancement of Children's Mental Health, training has started with the aim of having childcare providers serve as mentors and supporters to parents with children who have emotional or behavioral difficulties. The Dodge County Collaborative Team has also started a Family Night which is geared toward teaching parent-child interaction skills and resources. Training and support is also in the planning stage through a request by the S.A.F.E. mental health subcommittee to Alegent Health-Midlands Hospital. PTI-Nebraska already has parent training, support, and a mentor program established. There is a need to help those children and families that are Borderline in meeting the criteria for acceptance into programs or qualifying for resources.

In South Central Nebraska, Families CARE is an organization that provides advocacy, resources, and education to families who have children with diagnosable mental health, emotional, and/or behavioral disorders. Y.E.S. is a program for youth and lead by youth, who have a diagnosable mental health, emotional, and/or behavioral disorder. They provide education to professionals, families, and peers on mental health issues to reduce stigma within our communities in Region 3. Presently there are four groups that meet in Holdrege, Hastings, Grand Island, and Kearney. Y.E.S. is in the planning process of expanding to Broken Bow area and they continue to provide technical assistance to organizations and family groups around the country that have an interest in starting a similar group in their areas.

### **State Children's Goal #3: Integration of Service Systems**

#### **State Service System as it is envisioned for the Future:**

- We will collaborate across child serving systems to provide a system of integrated services for children with serious emotional disorders who have multiple and complex needs.
- Services are integrated, with linkages among child-serving agencies and programs and mechanisms for planning, developing, and coordinating services.
- Case management ensures that multiple services are delivered in a coordinated and therapeutic manner and services and supports are adapted to the child's changing needs.

Previous State Plan

FY03 Goal #3: To provide a system of integrated services for children with serious emotional disorders who have multiple and complex needs

The States Priorities and Plans to Meet Unmet Needs:

Together for Kids and Families is a two-year planning grant awarded to the Nebraska Health project, funded through the State Early Childhood Comprehensive Systems Grant Program administered by the Maternal and Child Health Bureau, U.S. Health and Human Services, is designed to achieve optimum outcomes for Nebraska's young children and their families through comprehensive system planning and collaborative effort among stakeholders. Members of the governor-appointed Early Childhood Interagency Coordinating Council serve as the project's advisory committee. The project's leadership team consists of more than 50 representatives from agencies and organizations involved or interested in the health and well being of young children and their families. This advisory committee holds quarterly meetings to stay apprised of work group progress, makes recommendations and informs participants of other early childhood initiatives to ensure coordination and collaboration.

Additionally, three crosscutting teams focus on the areas of data, policy alignment, and family involvement. These groups were formed based upon geographic, cultural and family diversity. Since work group training occurs in March, each group has had monthly contact, largely via conference calls, to work through the steps. The five focus area work groups first spent time identifying issues and researching current practices and resources in Nebraska and other states. Based upon their findings, all groups have achievement outcomes and are in the process of discussing strategies with the next step being identification of indicators to measure progress toward the desired goals. Draft plans are subject to review, including comments and suggestions. The family involvement group has focused on developing a parent opinion survey to gather information from parents across the state to ensure that they have a voice in the process. The group decided to conduct a targeted distribution and is working diligently to gather opinions from a diverse group of stakeholders. The policy alignment group has been reviewing the draft work to date, providing information and updating early childhood funding streams information. The data group has done research and provided each work group with the information they have requested on an ongoing basis. It is anticipated that a draft of the strategic plan will be completed by the end of this year. At that time, the plan will be available for review and recommendations to gain feedback prior to finalization.

**Source:** ABSTRACT, Nebraska's Comprehensive Early Childhood Strategic Planning Project, Nebraska Department of Health and Human Services, 2005.

**The Integrated Care Coordination Units (ICCU)** were developed and implemented to effectively manage at the local level the care of Nebraska children and families with multiple and complex needs. The program is designed to produce better outcome results in the lives of the children and families served at a cost savings to the State.

ICCU Care Coordinators provide intensive case management and ensure that care adheres to the principles of wraparound. Wraparound is a strengths-based process for services and supports that is individualized and based on the needs of the youth and his/her family. Care Coordinators from both HHS and Region III are trained in the areas of Protection and Safety and Family Centered Practice. ICCU is a truly integrated model, bringing together the delivery of child welfare and juvenile justice services through intensive case management and the Wraparound process.

Local Efforts:

In Southeastern Nebraska, with the transition of the Integrated Care Coordination Unit to Region V management, Region V Systems will be able to concentrate on the overall development and implementation of a children's regional system of care. This will build on the activities that have been associated with the F3 Lancaster County grant to expand into a larger regional system of care. There will be three primary phases to accomplishing this overall task, (1) consensus building, (2) enacting, and (3) sustaining.

- Consensus Building: This phase will focus on providing an opportunity to begin an ongoing dialogue with multiple stakeholders. The intent of this phase will be to predispose stakeholders in the issue of implementing system of care principles, impact on service provision, and overall system impact. During this phase, consensus will be sought to create the cultural shifts towards operating a children's regional system of care.
- Enacting: This phase will embark on building support structures for a regional system of care, including the development of a leadership team that will make recommendations to the Behavioral Health Advisory Committee and Regional Governing Board. Additionally, representation at various levels of the regional system will be developed to ensure integration of system of care principles.
- Sustaining: This phase will involve key steps to build ongoing technology transfer capability; to develop a performance indicator structure for management of system of care principles and outcomes; and define and implement flexible fiscal and regulatory systems capable of providing a resource base necessary for full implementation.

To begin the consensus building phase, a subcommittee has been developed that will do a number of community presentations throughout the region to open dialogue with multiple stakeholders. This process will be similar to that which Region V utilized during the initial planning stages of Behavioral Health Reform with emphasis on children's services.

In southeastern and eastern Nebraska, the Children's Services Initiative (CSI) group has formed to bring about change in assisting families in accessing mental health care. The group is comprised of family members of SED children, providers of services, Nebraska Health and Human Services staff and others who are concerned about children and their families. Proposed priorities include:

1. Nebraska residents of Lancaster, Douglas and Sarpy counties ages 0 to 19 will have continuous screening to detect behavioral health needs within one year of program implementation.

Criteria: Screening tools will be utilized by children's service agencies, child care providers, schools, pediatricians, behavioral health, parents, and family care providers to enable detection and referral.

2. Nebraska residents of Lancaster, Douglas and Sarpy counties ages 0 to 19 will have access to a coordinated system of behavioral health supports and services that is accountable within 2 years of program implementation.

Criteria: Ensure effective transition into an integrated system of care to increase coordination of family service connections.

The group meets every two weeks and is strategizing how to accomplish the above initiatives.

Eastern Nebraska: In Fremont, interagency collaboration is occurring to support families through a monthly family fun night with education on parenting issues and fun activities for the children. Blair has the "Families First Festival" hosted by the Youth Community Action Team, an interagency group of non-profits focused on youth issues and strengthening and supporting families. These groups are also helping to facilitate car seat checks and distribution of backpacks and school supplies. Additionally, the Dodge County Collaborative Team is supportive of efforts to help make landlords accountable for the living conditions at their rental properties as well as making affordable housing available for low-income and nearly homeless families.

Also in Eastern Nebraska, the contract network provider meetings give the providers a chance to talk about problems they have encountered, support each other, and discuss new programs they are starting. There are other examples of cooperation and planning to integrate services. The LB1184 treatment teams are good examples of strategizing and brainstorming the services for state wards with multiple and complex needs as well for the child and family's changing needs. The Coalition for the Advancement of Children's Mental Health is another. The CACMH recently had training on the Logic Model of Change, and has brought even more agencies to the table to participate in the discussions and to look at services to provide for those children with multiple and complex needs.

South Central Nebraska: Using a collaborative network of existing providers and new services that fill identified gaps, in February 2004, the Early Childhood Mental Health System of Care Project for Central Nebraska began to develop an integrated system of care for families with children from prenatal development to age five. A seven-county area of the Central District Health Department (Hall, Hamilton and Merrick counties) and the South Heartland District Health Department (Adams, Clay, Nuckolls and Webster counties) serves as the geographic framework for the project, which helps to underscore the importance of mental health as a public health issue.

This collaborative network is using existing public and private child-serving systems. These existing systems are partnered with new projects coordinated through a social, emotional and behavioral center at the Head Start Child and Family Development Program in Hastings. This community-based system is offering child-focused, family-centered and culturally responsive

services through a continuum of promotion, prevention and intervention. Some project components include:

- Classroom and child care observations and consultations;
- Training for both parents and providers;
- Perinatal depression screenings at an OB/GYN office; providing mental health referral information; disseminating early development and parenting information for waiting rooms and prenatal classes;
- A trained community and faith-based volunteers to visit a newborn's family, providing gifts of parenting materials and community resources contact information;
- Information and training to primary nurses of health care providers on performing a social/emotional screening of children 12 months to 4 years of age;
- A social, emotional and behavioral center with telemedicine capability; and
- A wraparound system for families with behaviorally troubled children.

This project is funded by a two-year grant, through a combined effort of the Nebraska Department of Education, the Nebraska Department of Health and Human Services, and the Nebraska Public Policy Center Promising Programs and Practices.

Regional Behavioral Health Authority Youth System Coordination in South Central Nebraska has focused efforts in the areas of strategic planning, family support, and the continued integration of service systems. 20 community teams, coalitions, councils, and advisory boards have brought stakeholders together, who are interested in services for families, to identify gaps and needs within communities and to implement strategies that will address these needs while building on collaborations to coordinate services to avoid duplication. Community (s) responses to gaps and needs:

- A dental office for homeless and uninsured individuals was added to the Crossroads Shelter. WeCAN Consortium is assisting with obtaining staffing.
- Stakeholders from the four largest counties within Region 3 are meeting to develop a model for addressing parental substance abuse that embraces the needs of the whole family.
- Five groups are planning for education and training on children's mental health through the development and implementation of a parent education program, a professional infant mental health association, a public radio campaign on behavioral health, a regional conference on infant mental health, and expansion of youth lead support groups.
- **Early Intensive Care Coordination (EICC)** is a unique program integrating mental health and child welfare while partnering with education, probation and child-serving systems to prevent children who have initially entered the child welfare system from removal from their home, or remaining in the system, and if removed to have their return to home expedited by using wraparound and family centered practices. It was piloted in fiscal year 2003, twenty youth and their families were served during fiscal year 2004 and due to the program's positive outcomes, its capacity has been expanded to serve 50 families in fiscal year 2005.

Western Nebraska:

**Youth Network:**

The purpose of the Youth Network in the Panhandle is to bring together area professionals, consumers, and community members to discuss strengths, issues, concerns, and events pertaining to youth and their families. The participants of the Youth Network are from a diverse population of the Nebraska Panhandle, and work in smaller sub-groups focused on specific action items regarding youth. As the title implies, this forum is a valuable opportunity to conduct networking between area community members, professionals, and colleagues. Youth Network meetings are held quarterly. Plans for the upcoming year include holding these and the following sub-group meetings in different areas of the Panhandle.

**Youth Network Sub-groups:**

1. ***Infant and Early Childhood Mental Health (IECMH):*** The purpose of the IECMH meetings is to bring together community members and professionals to discuss issues pertaining to Infant and Early Childhood Mental Health, ages 0-5 years. This includes a focus on prevention and early intervention. Past work has been initiated for this Panhandle group to become active in a statewide affiliation for Infant Mental Health. During this past year, special attention has focused on development of services for pregnant women with substance abuse issues. The IECMH meetings are held on a monthly basis.

2. ***Independent and Transitional Living Resources:*** The purpose of this meeting is to identify Panhandle resources that impact youth and young adults who are in independent and transitional living. There has been an identified need to synchronize the continuum of care, and inform communities about specific criteria and guidelines about resources to better serve the population of 14-25 year olds. Many of these youth and young adults have limited resources and have difficulty transitioning from youth to early adulthood. This also includes possible transition from state-ward to former-ward status, and those who are pregnant and/or parenting. It is the goal of this group to gather and distribute information about independent and transitional living resources to Panhandle communities, with the hope of reducing the number of youth returning to the system as adults. This group meets every other month.

3. ***The Mentoring Network:*** The purpose of the Mentoring Network meetings is to continue planning, recruitment, and support for Panhandle-wide mentoring efforts. It is intended that every child in the Panhandle in need of a mentor be served through combined efforts of this group. Participants of the Mentoring Network come from many agencies and community organizations, including churches, Panhandle Community Services, Professional Partner Program, ICCU, Cub Scouts, and Team Mates. Leaders in these organizations have been meeting for the past two years, with plans to hold a Mentoring Conference in August 2005. There is also interest across the state to develop a mentoring coalition that would include this group. Mentoring Network meetings are held monthly.

Also in Western Nebraska, use of the Family Centered Practice model, formally known as "Wraparound," has been advanced over the past year. This philosophy is the premise of both the Professional Partner Program and ICCU. Informal training has been expanded into Panhandle

Mental Health Center's therapeutic foster care program, Reach Out Foster Care, and the Regional Youth Network. During the next year, more formal training will be developed and available to all communities in the Panhandle.

In the upcoming year, Region I Youth Coordination will continue to focus on integration of its youth programs, including PPP, ICCU, and PMHC's Reach Out Foster Care. This has worked well in the past year by decreasing duplication of services, improvement of communication and efficiency between programs, and reduction of staff involvement with each case. The Youth Network and its sub-groups will continue to address specific needs to youth and families of the Panhandle. Challenges include recruitment and retention of qualified staff, accessing treatment resources from the Region's frontier area, and lack of funds to increase the number of youth served in both PPP and ICCU.

Region I Mental Health and Substance Abuse Administration continue to work with HHS, Magellan Managed Care, Inc., and Nebraska Medicaid to increase availability and accessibility of treatment services to youth in close proximity of their communities. In collaboration with NDHHS, and the Department of Education, Region I recently submitted a SAMHSA proposal for the Comprehensive Community Mental Health Services for Children and their Families. If awarded this grant, implementation of proposed service expansion for youth and families will begin in 2006.

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### **SECTION III – STATE PLAN: CHILDREN'S SECTION** **CHILD STATE PLAN (FIVE CRITERIA)**

#### **Criterion 1: Comprehensive Community- based Mental Health Service Systems**

- Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness.
- Describes available services, and resources in a comprehensive system of care, including services for individuals diagnosed with both mental illness and substance abuse. The description of the services in the comprehensive system of care to be provided with Federal, State, and other public and private resources to enable such individuals to function outside inpatient or residential institutions to the maximum extent of their capabilities shall include Health, mental health, and rehabilitation services; Employment services; Housing Services; Educational Services; Substance Abuse Services; Medical and dental services; Support services; Services provided by local school systems under the Individuals with Disabilities Education Act; Case management services; and Other activities leading to reduction of hospitalization.

#### **Organized community based system of care**

##### **Regional Systems of Care**

As a part of the six regional behavioral health systems in Nebraska, each Regional Youth Specialist takes the lead in pursuing the development of a **comprehensive system of care for children and families** within each Region. Each system should include an array of effective

services provided by highly trained staff, individualized care and coordination of services through a wraparound approach, families as equal partners at all levels, service provision and system design which is culturally competent, and an integrated service delivery system across mental health, education, child welfare, juvenile justice, and substance abuse services. This is provided through a community-state partnership. Youth specialists work to effectively manage the system to produce positive outcomes for children and families in a cost effective manner.

### **Available System of Treatment and Support Services Purchased**

At the present time, funding sources purchasing mental health services for children and adolescents are administered through the Nebraska Health and Human Services system. The Health and Human Services is administered by three agencies (Services, Finance and Support, and Regulation and Licensure) that are coordinated through the HHSS Policy Cabinet. The Department of Health and Human Services (HHS), Division of Behavioral Health is the Mental Health Authority for Nebraska and administers state and federal mental health block grant dollars through six regional mental health/substance abuse administrations that are county operated. The HHS Division of Protection and Safety is the combined child welfare/juvenile justice authority for the State and works closely with the Behavioral Health Division and Mental Health Regions to address the needs of children and adolescents with serious emotional disorders, who are wards of the state, and their families. The Medicaid Division is within HHS-Finance and Support and coordinates with the HHS Behavioral Health Division to administer Medicaid funding for child and family mental health. An Administrative Services Organization (Magellan) assists both agencies in utilization management, claims payment, and data collection for the public (Medicaid and non-Medicaid) behavioral health system. The Nebraska Department of Education administers state and federal education funding and has collaborated with the HHS Behavioral Health Division on school-based mental health services, early childhood mental health programs and vocational services for transitioning youth.

### **Funding Pathways for services**

Currently, federal block grant and state mental health dollars are administered through Health and Human Services, Office of Mental Health, Substance Abuse and Addiction Services via the six behavioral health regions. The Medicaid managed care program is administered by an administrative services only contract with Magellan Behavioral Health. Child welfare/juvenile justice funding is administered through the Department's Protection and Safety Division and local Health and Human Services Offices.

### **Mental Health and Substance Abuse Rehabilitation (and related\*) Services Provided:**

Public System	Medicaid EPSDT	Child Welfare/Juvenile Justice*
Mental Health Treatment: <ul style="list-style-type: none"> <li>• Outpatient Therapy</li> <li>• School Wraparound</li> <li>• Professional</li> </ul>	<ul style="list-style-type: none"> <li>• Outpatient Mental Health Treatment</li> <li>• Treatment Crisis Intervention</li> <li>• Day Treatment</li> <li>• Treatment Foster Care</li> </ul>	<ul style="list-style-type: none"> <li>• Early Care and Education</li> <li>• Parent Education</li> <li>• Family Support Groups</li> <li>• Home-Based Support</li> <li>• Intensive Family Preservation</li> <li>• Home-Based Therapy</li> </ul>

Partner Program <ul style="list-style-type: none"> <li>• Day Treatment</li> <li>• Home-Based Services</li> <li>• Therapeutic Foster Care</li> <li>• Respite Care</li> <li>• Therapeutic School consultation</li> </ul>	<ul style="list-style-type: none"> <li>• Treatment Group Home</li> <li>• Residential Treatment</li> <li>• Enhanced Treatment Group Home</li> <li>• Inpatient Hospital Services</li> </ul>	<ul style="list-style-type: none"> <li>• Non-Home Based Therapy</li> <li>• Respite Care</li> <li>• Day Treatment</li> <li>• Emergency Shelter Care</li> <li>• Foster Care</li> <li>• Group Care</li> <li>• Community-Based Evaluation</li> <li>• Tracker Services</li> <li>• Day/Evening Reporting Programs</li> <li>• Proctor Care</li> <li>• Support/Wraparound Services</li> <li>• Residential Evaluation</li> <li>• Electronic Monitoring</li> <li>• Youth Rehabilitation and Treatment Centers</li> <li>• Case Management</li> </ul>
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\*related services may have a mental health component or be provided as needed as a support service for children diagnosed as SED.

Substance abuse treatment services include:

The following substance abuse services are available to children under Criteria 1 through the Nebraska Behavioral Health system. Services are funded as the need is determined by the Behavioral Health Regions:

**- Youth Community Support:** The Community Support Program is for youth with an Axis I Substance Abuse Diagnosis or a Dual Disorder Diagnosis with a Primary Substance Abuse Disorder. Community Support is designed to assist substance abusing youth and their families to recognize substance abuse problems, and provide/develop the necessary services and supports which enable youth to live in the community with their natural family, foster parents or adoptive parents in a lifestyle free from substance abuse. The program should provide the youth with the ability to maximize quality of life in a substance free manner including participation in school and community. Community support staff will facilitate communication and coordination between multiple service providers that serve the same youth, including the school and educate and support parents to meet the specialized needs of the substance abusing youth. Community support provides youth advocacy, ensures continuity of care, and supports youth and their families in time of crisis. Staff will provide and procure youth and parent skill training in dealing with substance abuse and related issues, ensures the acquisition of necessary resources and assist the youth in achieving community/school/ /vocational integration in a lifestyle free from substance abuse, in a developmentally appropriate manner. The community support program provides a clear locus of accountability for meeting youth and related family needs with the resources available within the community. The role of the community support worker may vary, and services are generally provided out of office in community locations consistent with individual youth need.

**- Youth Partial Care:** Partial Care Programs provide group-focused, non-residential services for substance abusing youth or dually diagnosed youth who require a more restrictive treatment environment than that provided by outpatient counseling, but do not require a residential program. Activities of this program must focus on aiding youth and their families in recognizing their substance abuse problems, and assisting youth to develop knowledge and skills necessary for making lifestyle changes necessary to maintain a life free from substance abuse. Partial care staff will work cooperatively with the schools to support successful educational performance by the youth, documenting that educational services have been maintained while in care. Adequate professional structure to prevent immediate relapse must be provided. Partial care would average, at the minimum, 30 hours per week of structured activities and may include individual, family and group counseling services. **Youth Therapeutic Community:** Therapeutic Community programs provide long term comprehensive residential treatment for substance abusing or dually diagnosed youth for whom shorter term treatment is inappropriate, either because of the pervasiveness of the impact of substance abuse on the youth's life or because of a history of repeated short term or less restrictive treatment experiences. These programs provide psychosocial skills building through a long term, highly structured set of peer oriented treatment which defines progress toward individual change and rehabilitation. Activities are developmentally appropriate for youth, and incorporate a series of defined phases. The program is staffed on a 24 hour basis, and has access to on call medical personnel. Youth educational needs may be met on site.

**- Youth Short Term Residential** (funded through Age Waivers as requested): Short Term Residential programs provide highly structured (24-hour) comprehensive services for substance abusing youth or dually diagnosed youth who require a more restrictive treatment environment to prevent the use of abused substances. For a youth to be eligible for services there must be documentation from a youth assessment that shows that there is no reasonable chance of maintaining youth in their family and educational environment during treatment. Activities of this program must provide daily structure to prevent access to abused substances. The program must focus on developmentally appropriate ways to develop the knowledge and skills necessary to maintain a life free from substance abuse. Short Term Residential services must be integrated into the continuum of a youth's care to allow youth to move from a residential to a less restrictive placement. The expected duration of treatment is no more than 45 days.

**Youth Halfway House:** Youth Halfway House programs provide transitional residential treatment services for youth seeking to re-integrate into the community, generally after short term or intermediate residential treatment. These programs must provide a structured set of activities designed to develop the independent living skills necessary to remain free from substance abuse outside a residential treatment setting. They should assist the youth in returning home or accessing a temporary family home environment. The program must also focus on assisting youth to maintain educational involvement.

**Youth Intensive Outpatient:** Intensive Outpatient provides group focused, non-residential services for substance abusing youths who require a more structured treatment environment than that provided by outpatient counseling, but who do not require a residential program. Activities must focus on aiding youth to recognize their substance abuse problems and to develop knowledge and skills for making lifestyle changes necessary to maintain a life free from substance abuse. It is a non-residential, facility based, multi-service program centered around

group counseling services designed to stabilize and treat youth with moderate to severe substance abuse problems. Other services could include: 24 hour crisis management, individual counseling; education about AOD issues, family education and counseling, self help group and support group orientation.

- **Youth Outpatient Therapy/Evaluation:** Outpatient therapy is a specialized substance abuse program for youth experiencing a substance abuse problem that causes moderate and/or acute disruptions in the youth's life. Outpatient programs provide individual, family, and group treatment services, generally on a regularly scheduled basis. The outpatient program provides each youth served the appropriate assessment and/or diagnosis of the substance abuse problem, as well as effective treatment to change behaviors in order to attain and maintain a substance abuse free lifestyle. Programs may include collateral or adjunctive services. Adjunctive services are designed to link and coordinate other services necessary for the youth, in order to achieve successful outcomes. These services may include information gathering and reporting, coordination of services, referral facilitation, and related activities to assure coordination between programs.

- **Assessment Only:** Assessments are conducted by a Certified Alcohol/Drug Abuse Counselor to evaluate youth that exhibit behaviors which may be indicative of a substance abuse problem. Such an assessment would attempt to determine if a substance problem exists, the extent of the problem, identify biopsychosocial and other contributing factors, and recommend what, if any, treatment is needed. An assessment should specify youth strengths and weaknesses, which will aid in formulating a treatment plan. Standardized screening and assessment tools may be used when conducting a substance abuse evaluation.

### **Description of the State's Case Management System**

Children and adolescents with serious emotional disorders receive **case management** through the mental health programs that serve them. Regulations require that all mental health programs funded by the Department that serve children and adolescents have policies and procedures to ensure that families and youth with serious emotional disorders needs are actively involved in treatment planning and have the skills necessary to support and maintain those treatment goals. Documentation on the service record must reflect the service recipient's treatment/rehabilitation needs and experience. The plan should be of the kind and quality to facilitate service planning, evaluation, and continuity of care. Those programs determine criteria for eligibility for case management.

**Medical Services** may be provided through funds in the MATERNAL AND CHILD HEALTH BLOCK GRANT STATUTORY AUTHORITY: Chapter 21, Article 22, R.R.S., 1943. The administering agency is the Department of Health and Human Services/Finance and Support. Under Title V of the Social Security Act of 1935 as amended, Nebraska receives federal funding to address the health needs of all mothers and children, with particular responsibility towards low-income individuals or other populations with limited access to care. The projects provide services to low-income, high risk group mothers and infants, to children and adolescents and to children with **chronic handicapping or disabling conditions**.

The following services are provided through projects targeted for children and adolescents: prenatal education, home visits, health screening, direct care and follow-up to pregnant

adolescents; health screening, history, physical examinations, nutrition counseling and anticipatory guidance; acute and chronic care; preventative and simple intervention dental care; mental health services; immunizations; access to Health Check services through Medicaid; teen pregnancy prevention education and intervention; nutrition education; and dental health and dental education services.

**Dental Services** may be provided by the Dental Health Program, which provides comprehensive dental services for children who would not otherwise receive care because of economic or other reasons beyond their control. This program is funded by the Maternal and Child Health Block Grant. The Dental Health of Children Program serves school and preschool age children from low-income families who do not qualify for Medicaid. The Program serves as an entry point into the dental health delivery system for eligible children and to improve the quality of services necessary to prevent disease and restore and maintain oral health.

Project services include preventative services, examination and diagnosis, treatment, correction of defects, and aftercare.

In Nebraska, these programs located in rural areas are structured so as to utilize the services of private dental practitioners through contractual agreement. Four community action agencies in Richardson, Nemaha, Dakota and Red Willow counties determine client eligibility and refer eligible children to one of the approximately 30 contract dentists in 10 counties. This program serves approximately 300 children a year.

**Housing** and other **support needs** are addressed through referral to appropriate services. For youth diagnosed with a serious emotional disturbance who are at risk of being placed out-of-home, becoming a state ward, or committing a juvenile offense, **case management** is provided through the Professional Partner Program, funded by the Office of Mental Health, Substance Abuse and Addiction Services. This program includes strength-based assessment, treatment planning, brokering services, and monitoring plan implementation.

**Prevocational/Employment services** for children with serious emotional disturbances are also provided through the public school system under the provision requiring **transition services**. The term transition services means a coordinated set of activities for a student with a disability that is designed within an outcome-oriented process, which promotes movement from school to post-school activities, including post-secondary education, vocational training, integrated employment (including supported employment), continuing and adult education, adult services, independent living, or community participation; is based upon the individual student's needs, taking into account the student's preferences and interests; and includes instruction, related services, community experiences, the development of employment and other post-school adult living objectives, and, when appropriate, acquisition of daily living skills and functional vocational evaluation. Transition services for students with disabilities may be special education, if provided as specially designed instruction, or related services, if required to assist a student with a disability to benefit from special education.

The Workforce Investment Act is the first major reform of America's Job Training System in fifteen years. It was signed into law by President Clinton on August 7th, 1998. Programs and providers will co-locate, coordinate and integrate activities and information, creating a coherent and accessible one-Stop system for individuals and businesses. Empowering Individuals .Individual Training Accounts (ITA's) at qualified institutions will supplement financial aid from other sources and may pay for all the costs of training. A system of consumer reports will provide key information on the performance outcomes of training and education providers. Through ITA's, participants choose training based on program outcomes. To survive in the market, training providers must make accountability for performance a top priority. Significant authority is reserved for the Governor and chief local elected officials to implement an innovative and comprehensive workforce investment systems tailored to local and regional labor market needs. Programs will be linked more closely to local labor market needs and community youth programs, with strong connections to academic and occupational learning.

"One-Stop" Centers serve as the cornerstone of the new Workforce Investment System. These Centers will unify training, education and employment programs into one customer-friendly system in each community. At least one full-service center will be located in each workforce investment area. Strategic Goals for Improved Youth Programs include:

Local areas will be encouraged to take advantage of the School-to-Work network and existing partnerships in their areas. Collaborative planning with the schools and School-to-Work partnerships should include: preparation of all youth for adulthood, successful careers and lifelong learning, in addition to strengthening basic skills. School-to-Work partnerships can assist local Workforce Investment boards and youth councils in providing continuity between Workforce Development and the education system. The chief elected official, as the local grant recipient for the youth program, is a required One-Stop partner and is subject to the requirements that apply to such partners.

CORE MEASURES OF PERFORMANCE include:

- YOUTH AGE 19-21: Entry into unsubsidized employment; 6-months retention in unsubsidized employment; 6-months earnings received in unsubsidized employment; and attainment of educational or occupational skills credential.
- YOUTH AGE 14-18: Attainment of basic, work readiness, and/or occupational skills; Attainment of secondary school diplomas/equivalents; Placement and retention in postsecondary education/training; or placement in military, employment, apprenticeships.

Family Support Organizations: Another component of the service array system in the community is the family support organizations in each of the six behavioral health regions. The Office of Protection and Safety and the Division of Behavioral Health Services continue to contract with family organizations for support with the initiative "Families Mentoring & Supporting Other Families." These are strength-based, family centered, and partnership oriented supports to parents across the State of Nebraska whose children have been made state wards, or are in a voluntary case, or parent who are involved with the department as a result of a report of abuse/neglect, or parents whose children are diagnosed with a serious emotional disturbance and

substance dependence disorders. The intent is to ensure that parents have a voice, ownership and access to the systems of care for their child (i.e. case plans, individual educational plans, treatment plans and any other care plan).

The Department contracts with organizations interested in working with the State to build support services to families that will focus on providing parents with an understanding of wraparound services through peer role modeling and coaching. The philosophy of wraparound includes individualized services that are developed through professionals and parents in partnership where both are serving important roles in service delivery. Services are tailored to meet the individualized needs of the child and family and based upon strength-based assessments.

In Addition, NAMI Nebraska has purchased the training “**Visions for Tomorrow**” to provide training for families in Nebraska. The course was slated to start in September 2004. These educational workshops are designed for caregivers of children and adolescents who have been diagnosed with a brain disorder as well as those who exhibit behavior that strongly suggests such a diagnosis.

Also, Nebraska Federation for Families, in conjunction with the two children’s mental health grants, has worked on legislative and policy initiatives to prevent families from needing to make their children state wards in order to access services. The Department has accessed technical assistance to help them in this initiative.

<b>GOAL #1:</b>	Maintain capacity of Professional Partner (wraparound) program for children with serious emotional disturbance.			
<b>POPULATION:</b>	Children and adolescents with serious emotional and behavioral disorders			
<b>OBJECTIVE:</b>	The number of children participating in Professional Partner wraparound program will be maintained.			
<b>CRITERION:</b>	#1 Comprehensive, community-based mental health system.			
<b>BRIEF NAME:</b>	Children enrolled in Professional Partner.			
<b>INDICATOR:</b>	The number of children participating in Professional Partner services.			
<b>MEASURE:</b>	Count of number of children participating in Professional Partners as of June 30 of each year.			
<b>SOURCE OF INFORMATION:</b>	Magellan Behavioral Health, Professional Partner Annual Report (2004)			
<b>Performance Indicator</b>	<b>FY 2004 Actual</b>	<b>FY 2005 Estimated</b>	<b>FY 2006 Objective</b>	<b>% Attain</b>
Children in Professional Partner	849*	345	345	

\*Includes children served under Federal System of Care Grant; in FY05, many of those children were transferred and served in Integrated Care Coordination Units (wraparound) funded through Protection and Safety

**Criterion 2: Mental Health System Data Epidemiology**

- Contains an estimate of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children; and
- Presents quantitative targets to be achieved in the implementation of the system of care described under Criterion one (1).

Regarding census data, see Adult Criteria 2.

URS Table 1: Estimated Number of Children and Adolescents, Age 9 to 17, with Serious Emotional Disturbance, by State, 2004

State	Number of Youth 9 to 17	Age 5 - 17 Percent in Poverty	State Tier for % in Poverty	Level of Functioning Score=50		Level of Functioning Score=60	
				Lower Limit	Upper Limit	Lower Limit	Upper Limit
Nebraska	221,460	8.60%	Low	11,073	15,502	19,931	24,361

In 2004, based on this, it is estimated Nebraska has 22,146 Children and Adolescents, Age 9 to 17, with Serious Emotional Disturbance.

Source: State Data Infrastructure Coordinating Center, National Association of State Mental Health Program Directors Research Institute, Inc. (NRI) under contract with the Federal Center for Mental Health Services (CMHS) (contract no. 280-99-0504) August 2005. Uniform Reporting System (URS) Tables and Information <http://www.nri-inc.org/SDICC/SDICC05/05files.cfm>

Nebraska is engaging in a number of activities to expand service delivery to serve more children and adolescents with serious emotional and behavioral disorders including the following:

- Provide an array of services to the highest need youth in the all areas of the Protection and Safety system
- Refine a system of telehealth which will improve access to mental health care for all youth (and adults) experiencing a behavioral health emergency
- Continue to conduct point-in-time survey to analyze and target resources to better meet the mental health and substance abuse needs of state wards
- Conduct needs assessment in each mental health region identifying the services available, gaps in services, and priorities for service development

<b>GOAL #2:</b>	To maintain the number of persons age 0-17 receiving services through the Nebraska Behavioral Health System.
Population:	Children and adolescents receiving Mental Health Services
Objective:	The number of children receiving services will be maintained
Criterion:	#1 Comprehensive, community-based mental health system
Brief Name:	Persons age 0-17 receiving services
Indicator:	The number of children receiving services
Measure:	Count of number of children receiving services
Source Of Information:	Magellan information management system

<b>Performance Indicator</b>	<b>FY 2004 Actual</b>	<b>FY 2005 Estimated</b>	<b>FY 2006 Objective</b>	<b>% Attain</b>
Children receiving services	1,776	2,262	2,265	

**PENETRATION/UTILIZATION RATES**

Federal Estimated number of youth in Nebraska with Severe Emotional Disturbance	<b>23,537</b>
Total number of youth served by NBHS in FY 2005	2262
Total number of youth with SED served by NBHS in FY 2004	273

**Magellan Behavioral Health / Unduplicated Persons Served / FY2005/ Age 1 – 17 yrs**

	<b>N</b>	<b>%</b>
<b>TOTAL ADULTS SERVED</b>	2262	
<b>By Age:</b>		
0 - 3 years	48	2.12
4 - 12 years	913	40.36
13 - 17 years	1301	57.52
<b>By Gender:</b>		
Male	1322	58.44
Female	940	41.56
<b>Employment Status:</b>		
Student		0.00
Unemployed	49	2.17
Disabled		0.00
Employed - Full-Time	33	1.46
Employed - Part-Time	198	8.75
Homemaker		
Other	1982	87.62
Unknown/Not reported		
<b>Race:</b>		
White	1833	81.03
Black/African American	169	7.47
American Indian	112	4.95
Asian/Pacific Islander	27	1.19
Alaskan Native		
Other	121	5.35
Unknown/Not reported		
<b>Hispanic Origin:</b>		
Yes	158	6.98
No	2104	93.02
<b>Legal Status at Admission:</b>		
Voluntary	1798	79.49
Court Order	156	6.90
Mental Health Board Commitment	1	0.04
EPC	86	3.80

Other	221	9.77
<b>By Services:</b>		
MH only	2067	91.38
SA only	177	7.82
Dual only	18	0.80

**Criterion 3: Children's Services**

- Provides for a system of integrated services appropriate for the multiple needs of children without expending the grant under Section 1911 for the fiscal year involved for any services under such system other than comprehensive community mental health services. Examples of integrated services include:
  - Social services,
  - Education services, including services provided under the Individuals with Disabilities Education Act,
  - Juvenile justice services,
  - Substance abuse services, and
  - Health and mental health services
- Establishes defined geographic area for the provision of the services of such system.

**State Level Departmental Systems:** At the state level, the Public non-Medicaid behavioral health system is administered by the Office of Mental Health, Substance Abuse and Addiction Services within the Department of Health and Human Services. Medicaid and the State Children's Health Insurance Program (Kid's Connection) is administered by the Medicaid Division of the Department of Health and Human Services Finance and Support. The child welfare and juvenile justice system is integrated and administered through the Protection and Safety Division of the Department of Health and Human Services. Education and Special Education are administered by the Department of Education.

**Service Integration and Collaboration Efforts:** The Mental Health Office and the Protection and Safety Division worked together on areas of mutual interest. Some of these areas have included developing parameters for systems of care, identifying behavioral health assessment devices to use in the HHS Protection & Safety System (Child Welfare/Social Services Department in Nebraska), developing integrated care coordination at the local level, developing wraparound training standards, and participating in Nebraska Family Portrait (planning effort for child welfare and juvenile justice). Collaboration with the Department of Education includes joint funding and development of school wraparound programs and a major initiative to address the mental health needs of young children and their families.

**Education Services:** Students diagnosed with a severe emotional disturbance qualify for special education services within the public school system. All students qualified for special education and related services under the Individuals with Disabilities Education Act (IDEA) and Nebraska's 92 NAC 51.

School districts are required to insure that all children with verified disabilities, from date of diagnosis to age 21, have available to them a free appropriate public education which includes special education and related services to meet their unique needs. The Department of Education

is responsible for establishing the standards for special education programs, reviewing programs and providing financial assistance. Children with disabilities must be verified in one or more of the following categories to receive special education: behavioral disorder, deaf/blindness, hearing impairment, mental handicap/mild, mental handicap/moderate, mental handicap/sever-profound, multiple disabilities, orthopedic impairment, other health impairment, specific learning disabilities, speech-language impairment, visual impairment, traumatic brain injury or autism.

Early Childhood Education Services include all special education and related services for children with verified disabilities from birth to age five. Services coordination for infants and toddlers with disabilities below age three is jointly administered by the Department of Health and Human Services and the Department of Education. Programs for children with disabilities of school age are organized by levels: Level I special education support services are those special education services provided to students who require an aggregate of not more than three hours of such services per week. Level I special education support services include all administrative, diagnostic, consultative and vocational adjustment counselor services. Level I and Level II combination special education services shall mean those special education programs which serve both Level I and Level II students in a combined program. Level II special education services are those special education and related services which are provided outside of the regular class program for a period of time exceeding an aggregate of three hours per week. Level III special education contractual services are those special education and related services provided in an educational setting not operated by the resident school district whose rates are approved by the Department of Education.

Educational needs of students diagnosed with a severe emotional disturbance will be met in the least restrictive environment. Prior to verification for special education services, students and their parents will meet with teachers, administrators and other related staff to determine student needs and how best to meet them. Often times, in Nebraska, the family may be accompanied by a Professional Partner, a professional trained in wraparound services, to assist the team in finding innovative solutions for assisting teachers to meet needs and allow students to remain in the regular classrooms. Tutoring and mentoring services are often provided to assist in these efforts. However, wraparound may include any innovative solution proposed and approved by the team and is not limited to a finite list of services. Other times, parents may be accompanied by other parents of SED children as part of the family organization's efforts to provide advocacy for students and their families. Students are eligible to receive supplementary aids and services and support services.

Should the student's educational needs not be met by the above efforts, the resident school district shall conduct a full and individual initial evaluation for each child being considered for special education and related services before the initial provision of special education and related services to a child with a disability. Services may be provided as described below:

- Services shall mean transportation and such corrective, developmental, and other supportive services as required to assist a child with a disability to benefit from special education, and includes speech-language pathology and audiology services, psychological services, physical and occupational therapy, recreation, including therapeutic recreation, early identification and

assessment of disabilities in children, counseling services, including rehabilitation counseling, and medical services for diagnostic or evaluation purposes. The term also includes school health services, social work services in schools, parent counseling and training, and orientation and mobility services.

- Assistive technology service means any service that directly assists a child with a disability in the selection, acquisition or use of an assistive technology device. The term includes the evaluation of the needs of a child with a disability, including a functional evaluation of the child in the child's customary environment; purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices by a child with a disability; selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing or replacing of assistive technology devices; coordinating and using other therapies, interventions, or services with assistive technology devices, such as those associated with existing education and rehabilitation plans and programs; training or technical assistance for a child with a disability, or if appropriate, that child's family; and training or technical assistance for professionals (including individuals providing education or rehabilitation services), employers, or other individuals who provide services to, employ, or are otherwise substantially involved in the major life functions of the individual with a disability.

A relatively new effort is the comprehensive plan of the Center on Behavior at the Center for At-Risk Children's Services, University of Nebraska-Lincoln, to implement and evaluate a three-tiered (i.e., universal, selected, indicated) prevention program, and to discuss the first year of implementation. Clear evidence regarding the overall and intervention specific effects of comprehensive three-tiered school-based prevention programs on children's social adjustment is critical as schools attempt to ensure that all children achieve social and academic success. Teachers report that they are unprepared to deal with problem behaviors exhibited by children with such and parents are concerned about problem behaviors within schools. Individual students are also affected, as the research paints a consistently bleak picture of post-school adjustment of students with emotional and behavioral (EBD) disorders.

In response to this growing concern, three-tiered behavior prevention programs have been recommended to help schools create more positive teaching and learning environments.

In general, three types of children exist in any school setting: (a) typical children not at risk of problems (80-90% of all students), (b) children at risk for developing antisocial behavior problems (5-15% of students), and (c) children who show signs of life-course persistent antisocial behavior patterns and involvement in delinquent acts (1-7%). Members of each group are candidates for differing levels of types of intervention that represent greater specificity, comprehensiveness, expense, and intensity. Universal, selected, and indicated levels of prevention are appropriate for each child group, respectively. To be maximally effective, prevention approaches must be directly linked to and coordinated with each other and the context of a school and community.

#### **Indicated Program: Multisystemic Therapy (MST)**

Purpose: The purpose of the indicated level intervention is to implement and examine the short- and long-term effects of Multisystemic Therapy on the social adjustment and academic achievement of children experiencing significant behavior problems. MST is a family- and

home-based treatment that strives to change how children function in their natural settings - home, school, and the community - in ways that promote positive social behavior while decreasing antisocial behavior.

Target Population: MST is implemented with kindergarten to third grade children who are school-system identified with an emotional disturbance/behavior disorder, have a DSM-IV diagnosis, or exhibit maladaptive behavior that is judged in the clinical range on a standardized measure. It is anticipated that 30 children and families will be served in the 2002-2003 school year.

Referral to MST: Because of caseload restraint and the need for a wait-list control group, the referral process was as follows: (a) The school's principal or special education coordinator generated a list of 6 students that met the identification requirements; (b) A school representative contacted the family and informed the caregivers about the availability of MST services and determined their willingness to participate in an information meeting to learn more about MST; (c) If the family agreed, a MST therapist and university representative met with the family to solicit participation in the project and sign consent forms; and (d) Students were randomly assigned to either an immediate treatment or wait-list control group.

Outcome Measures: The outcome measures are the same as those described for the First Step to Success intervention. By providing a comprehensive, three-tiered model across multiple risk factor domains, we hope to (1) prevent problem behavior from developing, (2) reduce the number of at-risk students currently identified, and (3) change life-course persistent maladaptive behavior patterns for children exhibiting significant behavior problems. Through extensive, systematic training, implementation, and evaluation activities, we will be able to test the model regarding the overall and intervention specific effects of a three-tiered behavior prevention program.

**Developmental of Local Systems of Care:** Public non-Medicaid behavioral health services are administered at the local level by the six mental health regions, which are county operated. Efforts to develop local systems of care focus on two Center for Mental Health Services Comprehensive Children's Grants. The Department of Health and Human Services in conjunction with the Nebraska Department of Education and Region III Mental Health Administration received a Comprehensive Community Services grant designed to establish an integrated system of care in 22 central Nebraska counties. In addition, the Department, in conjunction with Region V Behavioral Health and Lancaster County, has received a second grant which focuses on the developing a comprehensive system of integrated care to address the mental health needs of youth in the juvenile justice system. In each mental health region, Youth Specialists are working to achieve the following goals: Assessing the behavioral health needs of children and their families in the region and identifying gaps in services; Developing and implementing strategies for development of an array of effective behavioral health and related services; Developing strategies to ensure services are coordinated and care is individualized; Developing strategies to ensure parents and other family members of children in services are equal partners at all levels; Developing strategies to ensure service provision and system design

are culturally competent; Developing strategies for integration of service delivery and resources across mental health, substance abuse, child welfare, juvenile justice, and education. Developing strategies to effectively manage care to produce positive outcomes for children and families in a cost effective manner.

**Integrated Care Coordination:** One of the key initiatives in system of care development is the Integrated Care Coordination Project. Region III Behavioral Health Services and the Central Service Area of the Department of Health and Human Services, and other system partners, has developed the **Integrated Care Coordination Unit (ICCU)**. The ICCU is a program promoting an individualized system of care for high-need state wards in Central Nebraska. The youth served are those in Agency-Based Foster Care and higher levels of care. Funding is through a cooperative agreement between Region III and the Department of Health and Human Services on a case rate basis.

The ICCU is a public care coordination collaborative that includes the Department of Health and Human Services Division of Protection and Safety and Region III Behavioral Health Services Care Coordinators who will ensure that care is individualized and adhere to wraparound principles including: A no reject/eject philosophy; A comprehensive assessment to determine the child and family's needs; A child and family team consisting of both professionals and non-professionals who know the child and family; A Care Coordinator, with a caseload of 1:10, to facilitate the child and family team; Development of an Individualized Child/Family Support Plan based on the strengths of the child and family; Strategies that are individualized to the child and family's needs and based on the family's cultural background; Through flexible funding, purchase of services and supports identified in the plan; Use of community teams to broker informal resources to support families; Monitoring of outcomes and modification of strategies to produce better results

Other important system components include **Families Care**, a family operated support and advocacy organization for families of children with serious emotional and behavioral issues, the HHS/Region III **Care Management Team** which provides utilization management/review, a strong cross agency **Program Evaluation** component which collects demographics, service utilization, cost, and outcome data, and the **ICCU Director's** with membership consisting of key representatives of the three system partners (Families CARE, Health and Human Services and Region III) which has oversight responsibilities for services to children and families in Central Nebraska.

#### INTEGRATED CARE COORDINATION

**Integrated care coordination is provided by system partners.** Care coordinators perform strength-based assessments, bring together and facilitate the Child and Family Team, help determine needs and resources with the child and family, assist the team in identifying services and supports to meet those needs, and monitor implementation of the individual/family support plan.

System partners providing care coordination include the HHS Central Service Area and Region III Behavioral Health Services. There will be two Integrated Care Coordination Units serving 100 children and adolescents each. Each integrated unit will consist of five Health and Human Services Care Coordinators and five Region III Care Coordinators with each managed by a Care Coordination Supervisor. One supervisor will be employed by the Department of Health and Human Services and the other by Region III Behavioral Health Services.

The **Care Coordination** component combines an ecological assessment and treatment planning process that utilizes the wraparound approach through intensive therapeutic care management. At the center of this program is the Care Coordinator, who works in full partnership with each youth and his or her family. The program is strength-based, family-centered and acknowledges families as equal partners. It promotes utilization of the least restrictive, least intrusive developmentally appropriate interventions in accordance with the strengths and needs of the youth and family within the most normalized environment.

Care Coordination utilizes specific methods for moving toward an interagency system of care by developing referral sources, collaborative working relationships, and integration and coordination with families and public and private child serving systems. The mix, intensity, duration and location of services and supports are individually tailored to meet the unique needs of each youth and his or her family.

The program is based upon the wraparound approach to service delivery relying on the natural support systems of the family in their neighborhood and community. The program also holds the belief that as the needs of a child and his or her family become more complex, the interventions, services and supports they receive will become more individualized.

The Care Coordinator utilizes the wraparound process in order to build a team dedicated to flexible, nontraditional and unconditional care. A **Child and Family Team** is developed for each child and family served in the program. The youth and family identify those individuals they desire to participate on the team. The Child and Family Team generally consists of individuals who know the family best and are willing to work to help the child and family have a better life.

The Child and Family Team creates the **Individual Family Support Plan (IFSP)** that includes family goals and safety (individual, family and community) planning. The Team supports the implementation of the IFSP and inspires unconditional commitment to the child and family. The Team also identifies and implements informal supports that will be important to the success of the family long after formal services are gone.

**Informal services and supports are utilized to support the child and family in the community.** The care coordinator and Child and Family Team identify these supports designed to remain with the family far beyond the time the family receives formal services. These services and supports can often be accessed for little cost and offer the advantage of being there long-term because they are the fabric of community life.

**Family support, education and advocacy** is provided through Families CARE, the family support organization in Central Nebraska, provides a valuable resource to assist families through individual family advocacy, family support groups, outreach, evaluation, information dissemination, and a lending library. Care Coordinators have access the necessary family support services.

Another Federal Grant was received in Lancaster County. Families First and Foremost (F3), an organization that arose from a 7 million dollar federal grant to establish in Lancaster County a comprehensive system of mental health and other support services for youth is serious emotional disorders who are in or at risk of entering the juvenile justice system. Though the name F3 might be unfamiliar to you, the changes it's bringing to the community may have already improved the lives of neighbors, friends, and even own family members. F3's mission is to enhance and reshape plans of care for youths whose emotional disorders have led to criminal activity, substance abuse, and other forms of behavior problems.

Cultural Competence within the System of Care Nebraska Family Central is conducting strategic planning and program evaluation regarding cultural competence for the system of care.

Components that are measured include:

- Family Perception of cultural competency
- Analysis of demographics of service population as compared to the general population to examine systemic cultural biases.
- Ensure cultural competence training for providers
- Assess the cultural and demographics of providers (staff) to ensure that staff reflect the demographics of consumers

F3 is also pioneering the idea of "cultural competence," which is one of the grant's core values. Cultural competence means that the system recognizes that the way youths respond to treatment is often influenced by cultural factors. For example, a child from the Middle-East might bring different psychological and emotional issues to treatment than a youth of Asian or Latino heritage. To address those differences, F3 includes among its partners community-based agencies such as Faces of the Middle-East, Indian Center, Hispanic Center, Asian Community and Cultural Center and beyond.

This attention to detail and the shared commitment of a wide and diverse network of community stakeholders who have compassion and concern for the county's at-risk youth, making F3 an important and truly unique program. The community should be aware of the way it is transforming juvenile rehabilitation by challenging the status quo with a spirit that embodies its motto: Some Things Do Change.

<b>GOAL #3:</b>	To provide a system of integrated services for all children with serious emotional disorders who have multiple and complex needs
<b>POPULATION:</b>	Children served who are wards of the state
<b>OBJECTIVE:</b>	The number of children who are in the custody of the state and who receive integrated care coordination will be maintained.
<b>CRITERION:</b>	Children's Services

<b>BRIEF NAME:</b>	Integrated care coordination for state wards			
<b>INDICATOR:</b>	The number of children receiving integrated care coordination			
<b>MEASURE:</b>	Count of children receiving integrated care coordination			
<b>SOURCE OF INFORMATION:</b>	Program administrator report			
<b>SIGNIFICANCE:</b>	Emerging body of research indicates intensive case management using the wraparound approach can be effective in ensuring appropriate services and reducing expenses of using high cost services			
<b>Performance Indicator</b>	<b>FY 2004 Actual</b>	<b>FY 2005 Actual</b>	<b>FY 2006 Objective</b>	<b>% Attain</b>
Number of wards in ICCU per month	1000	1000	1000	

**Criterion 4: Targeted Services to Rural and Homeless Populations**

- Describes states' outreach to and services for individuals who are homeless;
- Describes how community-based services will be provided to individuals residing in rural areas.

**Outreach to the Homeless Population:** The Department receives PATH block grant funds from the Alcohol, Drug Abuse, and Mental Health Administration of the Federal Department of Health and Human Services to provide services to individuals who are homeless and mentally ill. The Department contracts with Regions I, II, III, V and VI Governing Boards, which subcontract with mental health providers for PATH grant services. The projects provide outreach, screening, and diagnostic treatment services, staff training, case management, support services in residential settings, referral, and other appropriate services to individuals identified as mentally ill and homeless. In addition, formal training presentations are made to staff concerning the needs of homeless emotionally disturbed persons. Case managers may facilitate the acquisition of income support, housing, and social services where feasible.

Children's mental health service providers are encouraged to collaborate with runaway and homeless shelters across the state. In fact, many of the local provider networks in the Mental Health Regions have included shelters as part of the formal network. The Comprehensive Community Services Grant provides a laboratory to develop a system of outreach for runaway and homeless youth in central Nebraska. The shelter in central Nebraska is an integral part of the provider network in that region.

**Rural School Based Wraparound:** One of the most effective efforts at serving children with serious emotional disorders in rural areas of the state has been the development of school-based wraparound. A major issue with many wraparound-planning efforts involves the intersection of the community, social service providers, and the schools. One of the most difficult problems is engaging school personnel to become full partners in the wraparound process. Developing a school-based support plan, as part of an overall wraparound plan is often complex due to language and system barriers between schools and other child and family team members. The

wraparound approach must include improved academic performance as well as behavioral functioning for children. Rural school wraparound services are provided in Regions I, III & IV.

**Ensuring services to children in rural areas:** There are six counties in Nebraska designated as "Metropolitan Statistical Areas" (MSA) by the U.S. Census Bureau. Using the Census Population as of April 1, 2000 for these "Metropolitan Statistical Areas," the Nebraska portion of the "Omaha, NE--IA MSA" includes Cass County (24,334), Douglas County (463,585), Sarpy County (122,595), and Washington County (18,780); the Lincoln, NE MSA contains Lancaster County (250,291); and the Nebraska portion of the Sioux City, IA--NE MSA is Dakota County (20,253). In April 2000, these six "Metropolitan Statistical Areas" counties had 899,838 people, accounting for 52.6% of the State of Nebraska population (1,711,263).

Numerator = At time of admission, Total Children with Serious Emotional Disorders Who Received Community Mental Health Services with a "County of Residence" (Magellan field # 15) outside of Douglas, Lancaster, Sarpy, Washington, Cass, and Dakota counties.

- exclude: Cass County, Douglas County, Sarpy County, Washington County, Lancaster County and Dakota County.
- include: 87 remaining Nebraska counties.

Data source: from Magellan Behavioral Health Information System, as under contract with NE HHS/ Office of Mental Health, Substance Abuse, and Addiction Services.

<b>GOAL #4:</b>	To maintain services to all children with serious emotional disorders in non-Metropolitan areas.			
<b>POPULATION:</b>	Children with serious emotional disorders living in non-Metro areas.			
<b>OBJECTIVE:</b>	The number of children in non-Metropolitan areas receiving services will increase.			
<b>CRITERION:</b>	Targeted Services to Rural and Homeless Populations.			
<b>BRIEF NAME:</b>	Non-Metropolitan children.			
<b>INDICATOR:</b>	Number of non-Metropolitan children with serious emotional disorders receiving services			
<b>MEASURE:</b>	Count of Non-Metropolitan children receiving services.			
<b>SOURCE OF INFORMATION:</b>	Magellan Behavioral Health Information System, as under contract with NE HHS/ Office of Mental Health, Substance Abuse, and Addiction Services.			
<b>SIGNIFICANCE:</b>	Assuring access to services for children with serious emotional disorders is a primary goal of the mental health block grant law.			
<b>1. Performance Indicator</b>	<b>3. FY 2004 Actual</b>	<b>FY 2005 Estimated</b>	<b>FY 2006 Objective</b>	<b>% Attain</b>
Number of children in non-Metropolitan areas receiving services	1264	1190	1200	

**Criterion 5: Management Systems**

- Describes financial resources, staffing and training for mental health service providers that are necessary for the implementation of the plan.
- Provides for training of providers of emergency health services regarding mental health.
- Describes the manner in which the State intends to expend the grant under Section 1911 for the fiscal year involved.

**Current Mental Health and Substance Abuse (State & Federal Block Grant) Funding**

State mental health and Federal Block Grant funds are administered through the HHS Division of Behavioral Health Services and are used primarily to fund services for persons who are not Medicaid eligible or to fund services not covered by Medicaid. These services include the Professional Partner Program, outpatient treatment, school wraparound (formerly called therapeutic consultation), respite care, day treatment, and home-based services.

Training of Providers of Emergency Health Services - See the adult Criteria 5 for information regarding training of providers of emergency health services regarding mental health.

**Description of the manner in which the State intends to expend the grant.**

See SECTION III – STATE PLAN A. Fiscal Planning Assumptions for Adults and Children

**Innovative Services.** A number of innovative services have been funded through federal block grant funds. These include the Professional Partner Program, and middle intensity services like day treatment and school wraparound.

**GOAL:** At least maintain the Per Capita State Expenditures for Community Mental Health Services

**OBJECTIVE:** By June 30, 2006, there will be at least the same level of spending in per capita state expenditures for children's community mental health services at \$7.62.

**POPULATION:** Total children's population ages 0-17 years.

**Per Capita State Expenditures for Community Mental Health Services:**

Numerator = Mental Health State Expenditures (as reported for the Maintenance of Effort section of the Block Grant Application)

Data source: Division of Behavioral Health Services

Denominator = per Capita ...Total children's population ages 0-17 years (450,242)

Data Source: Nebraska Databook, Last Updated on 5/21/01 based on data from U. S. Bureau of the Census Web site ([www.census.gov](http://www.census.gov)) 2001 <<http://info.ned.org/stathand/bsect8.htm>>.

1. Performance Indicator	3. FY 2004 Actual	FY 2005 Actual	FY 2006 Objective	% Attain
Value:	\$8.09	\$7.62	\$7.62	
Numerator	\$3,642,336	\$3,429,684	\$3,429,684	
Denominator	450,242	450,242	450,242	

**c) National Outcome Measures**

Table 4 NATIONAL OUTCOME MEASURES (NOMS)

**INDICATORS EXPECTED IN 2006 OR COMPLETE STATE LEVEL DATA REPORTING  
CAPACITY CHECKLIST \***

<b>1. Increased Access to Services*</b>	Number of Persons Served by Age, Gender, and Race/Ethnicity
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**POPULATION:** The persons served in mental health services in the Nebraska Behavioral Health System funded by the Nebraska Division of Behavioral Health Services as reported within the Magellan Behavioral Health Information System

**Value:** Total Persons Served (both children and adults) as reported on URS Table 2a & 2b

**GOAL:** To increase in the number of people receiving Mental Health Services.

**OBJECTIVE:** To increase by 5% the number of adults (age 18 or older), unduplicated count and at least maintain the number Children (age 0-17) served.

**POPULATION:** Persons served in mental health within the Nebraska Behavioral Health System (NBHS)

Performance Indicator	FY2004 Actual	FY2005 Target	FY2005 % Attained	FY2006 Target
Value: Adults	16,620	17,912		18,800
Value: Children	1,776	1,776		1,776

\*The data for FY2004 persons served. This is the first year of reporting the Federal Uniform Reporting System using the new capacity for data analysis in order to report an unduplicated count of persons served between the three Regional Centers (State Psychiatric Hospitals) using AIMS data and community mental health using Magellan Data. Summary from FY2004 Table 2A "Profile of Persons Served, All Programs by Age, Gender and Race/Ethnicity"

Table 2A. Profile of Persons Served, All Programs by Age, Gender and Race/Ethnicity

	ages 0-17		ages 18+		total
		18-20 years	1,062		
		21-64 years	15,014		
0-3 Years	179	65-74 years	342		
4-12 years	595	75+ years	195		
13-17 years	1,002	Not Available	7		
Total age 0-17	1,776	Total age 18+	16,620	Total all ages	18,396

<b>2. Reduced Utilization of Psychiatric Inpatient Beds*</b>	Decreased Rate of Readmission to State Psychiatric Hospitals within 30 days and 180 days
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POPULATION: Adults, Age 18 or older, Inpatient at the State Psychiatric Hospitals  
Lincoln Regional Center, Norfolk Regional Center, Hastings Regional Center  
Does not include transfers between regional centers or persons discharged for short-term treatment in a general hospital who are expected to return.

GOAL: Reduced Utilization of Psychiatric Inpatient Beds

**OBJECTIVE:** By June 30, 2006, the percentage of re-admissions to the Regional Centers decreased by 5%.

Value: Percentage of persons readmitted to Regional Centers within 30 days of discharge

Numerator: Readmitted within 30 days or within 180 days

Denominator: Number of discharges

<b>Percent of Discharges from State Regional Center inpatient units who were Readmitted within 30 days of discharge**</b>				
<b>FY2003 actual</b>	<b>FY2004 actual</b>	<b>FY2005 estimate</b>	<b>FY2006 target</b>	
6.1%	5.1%	3.6%	3.4%	Value
64	49	29*	28	Readmitted within 30 days
1,048	952	812	812	Number of discharges

<b>Percent of Discharges from State Regional Center inpatient units who were Readmitted within 180 days of discharge**</b>				
<b>FY2003 actual</b>	<b>FY2004 actual</b>	<b>FY2005 estimate</b>	<b>FY2006 target</b>	
18.1%	16.1%	Not Av.	15%	Value
190	153	Not Av.	122	Readmitted within 180 days
1,048	952	812	812	Number of discharges

\* estimated, based on 11 months of readmission data

\*\* Does not include transfers between regional centers or persons discharged for short-term treatment in a general hospital who are expected to return.

Prepared by Paula Hartig, July 20, 2005; Research and Performance Measurement; Financial Services Division; HHSS – Finance & Support

<b>3. Use of Evidence-Based Practices*</b>	Number of Evidence-based Practices Provided by State
	Number of Persons Receiving Evidence-based Practice Services

At this time, Nebraska does not have the capacity to report on this measure.

<b>4. Client Perception of Care*</b>	Clients Reporting Positively About Outcomes
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**GOAL:** Increase the Percent Reporting Positively About Outcomes.

**OBJECTIVE:** By June 30, 2006, increase the number of consumers responding Positively About Outcomes in the annual Nebraska Behavioral Health Consumer Survey.

**POPULATION:** all consumers with valid addresses and/or phone numbers within the Magellan Behavioral Health data base who do respond to the annual Nebraska Consumer Survey.

Value: the percentage responding positively

Numerator: average of positive responses to the MHSIP Consumer Survey: Perceptions of Outcomes questions (21. I deal more effectively with daily problems; 22. I am better able to control my life; 23. I am better able to deal with crisis; 24. I am getting along better with my family; 25. I do better in social situation; 26. I do better in school and/or work; 27. My housing situation has improved; 28. My symptoms are not bothering me as much).

Denominator: total number of responses

Numerator and Denominator Data Source: Nebraska annual consumer survey as reported on Uniform Reporting System / Implementation Report - Table 11. Summary Profile of Client Evaluation of Care using the official MHSIP consumer survey posted on [www.mhsip.org](http://www.mhsip.org).

#### Adult Consumer Survey Results

Performance Indicator:	<b>FY 2003 Actual</b>	<b>FY2004 Actual</b>	<b>FY 2005</b>	<b>FY2006 Target</b>
Value:	71.5%	89%	Not Available, survey underway	90%
Numerator	344	554		
Denominator	481	620		

#### Child/Adolsecent Consumer Survey Results

Performance Indicator:	<b>FY 2003 Actual</b>	<b>FY2004 Actual</b>	<b>FY 2005</b>	<b>FY2005 Target</b>
Value:	56.8%	53%	Not Available, survey underway	55%
Numerator	21	35		
Denominator	37	66		

Data source: from Nebraska Division of Behavioral Health Services  
Nebraska 2003 and 2004 Uniform Reporting System  
Table 11: Summary Profile of Client Evaluation of Care  
FY2005 data are being collected at this time.

**INDICATORS ENCOURAGED TO BE INCLUDED IN THE STATE PLAN IF STATE HAS CAPACITY TO REPORT**

<b>5. Increase/Retained Employment or Return to/Stay in School</b>	Profile of Adult Clients by Employment Status
	Increased school attendance

For “Increased school attendance”, at this time, Nebraska does not have the capacity to report on the measure.

Here is the report from the FY2004 URS Table 4. Profile of Adult Clients by Employment Status

<b>Adults Served</b>	<b>Total</b>	<b>% of Total</b>
<b>Employed:</b> Competitively Employed Full or Part Time (includes Supported Employment)	5,412	33%
<b>Unemployed</b>	1,962	12%
<b>Not In Labor Force:</b> Retired, Sheltered Employment, Sheltered Workshops, Other (homemaker, student, volunteer, disabled, etc.)	5,398	32%
<b>Not Available</b>	3,848	23%
<b>Total</b>	16,620	100%

For age 0-17 / employed total = 125 ... unemployed total = 76 ... not in labor force total = 1415

<b>6. Decreased Criminal Justice Involvement</b>	Profile of Client Involvement in Criminal and Juvenile Justice Systems
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At this time, Nebraska does not have the capacity to report on this measure.

**INDICATORS IN DEVELOPMENT**

<b>7. Increased Social Supports/Social Connectedness</b>	TO BE DETERMINED
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At this time, Nebraska does not have the capacity to report on this measure.

<b>8, Increased Stability in Housing</b>	Profile of client’s change in living situation (including homeless status)
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At this time, Nebraska does not have the capacity to report on this measure.

<b>9. Improved Level of Functioning</b>	TO BE DETERMINED
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At this time, Nebraska does not have the capacity to report on this measure.

Letter from Governor authorizing HHS staff to sign documents and receive notice for the Federal Community Mental Health Services Block Grant.

August 8, 2005

Ms. Lou Ellen M. Rice  
Grants Management Officer  
Office of Program Services, Division of Grants Management  
Substance Abuse and Mental Health Services Administration  
1 Choke Cherry Road, Room 7-1091  
Rockville, MD 20857

Dear Ms. Rice:

On behalf of the State of Nebraska, I hereby authorize the Director of the Department of Health and Human Services to make all required applications, agreements, certifications and reports related to the Community Mental Health Services Block Grant.

Nancy Montanez, Director  
Department of Health and Human Services  
PO Box 95044  
Lincoln, NE 68509-5044

Effective immediately and until further notice, please send all Grant Awards and similar notices concerning the Community Mental Health Services Block Grant to:

Ronald Sorensen, Behavioral Health Services Administrator  
Nebraska Department of Health and Human Services  
Division of Behavioral Health Services  
P.O. Box 98925  
Lincoln, NE 68509-8925

Thank you for your attention to this matter

Sincerely,

Dave Heineman  
Governor

Attachments: Federal Funding Agreements, Certifications and Assurances

Attachment A: Community Mental Health Services Block Grant Funding Agreements (FY2006)

Certifications

Disclosure of Lobbying Activities

Assurances